Please Type or Print in	Black Indelible Ink	Ensure All Copies Are Legible
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 2121 PM Antonina Ingegneri December 23 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Doctors Hospital Lanham Prince George's If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 1 F Hours Min. Director 219 12 2542 83 Nov. 19, 1921 Maryland Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic svent, the Medical Example must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Lanham 1 ☐ Yes 2 ☑ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9307 Annapolis Rod Funeral 20706 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes ZNo White Specify: þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor NASA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Gugliotta Grace Oliva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace I. Vick / Daughter 12803 Murphy Grove Terrace Clarksburg, MD 20871 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State `4 □ Donation 5 □ Other (Specify) Ft Lincoln Cemetery 12/29/2004 Brentwood, Maryland ice Licensee 22. Name and Address of FacilityHines Rinaldi Funeral Home 21. Signature of Fun al 19 11800 New Hampshire Ave Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE MYOCARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, 2 my, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 DEctopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🛣 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Medical Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funerel D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) N. 500 D-17874 12-23-04 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3717-38" S. M. NAYAR MD 20722 COTTAGE CVM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 27 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 004 42503 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** December 22, 2004 10:35 a.m Terryl Ingram /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** 40714 Lake and Breton View Drive St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** 1 ☐ M 2 🗷 F Michigan Director 386-40-9215 64 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If itam 27 is marked other than "natural", or Itams 23s or 28s-f show any injury or other traumatic event, the Medical Examinar manual be notified at once. 1 ☐ Yes 2 No Directo St. Mary's Maryland Leonardtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 40714 Lake and Breton View Drive 20650 <u>United States</u> Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Midowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Betty Webber Grier Jesse Terryl Harper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 40714 Lake and Breton View Drive, Leonardtown, Patricia Ingram / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Brinsfield-Echols Cr. 12-27-2004 | Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CANGER & BRATH METASTAGES **Physician** /Medical MONTHS Examiner SPEAST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be exect Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 ☐ Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No funeral dir Medical Certification; To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No n 24 hours after death.

Funeral Director: A pletely filled in by the fi death. 2 Accident 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) MD 056096 12.23.04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THREE NOTCH AS HOLLYWOOD 24035 LAUBINDER S · GILL 3. Registrar's Signature State Registrar

		1 - State of Maryland / Department of Health and M Certificate of Death	fental Hygie		42504
		Decedent's Name (First, Middle, Last)	2. Date of Death Month		3. Time of Death
Physic /Med		Janice Anita Jackson		Day Year 17 26 2004	5:54 M
Exam		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
		Washington County Hospital Hogerstown		Washington	1
Funera		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 Vrs. 7. Age (In yrs. last birthday) 1 Under 1 Vear If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Coun	
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yland		10a. State 10b. County 10c. City, Town or Location		1	Od. Inside City Limits
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ith the	Directo	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Coun	try?
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er de items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
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12 st hand 7 is n		19a. Informant's Name/Relationship (Type, Print) Richard T. Jackson/ Husband 19b. Mailing Address (Street and Number or Rural 18444 Woodside Dr. Hage			
ite, with yitality KILL 3-0000 s 1 and 2 should be filed within 72 hours after death with the Marylan t Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28e-f show other treumatic event, the Medical Examinational to notified at		20a. Method of Disposition 20b. Place of Disposition /Name of		Location - City or To	
Page nent o		XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 12/30 4 Donation 5 Other (Specify) Rest Haven Funeral Chapel	0/04 Hag	gerstown M	aryland
permit. Departr Import		21. Signatur of Funers See Licens 1 22. Name and Address of Facility Rest	t Haven F	meral Cha	pel
	N .	1601 Pennsylvania Av	ve Hagersi	town Maryl	and 21742
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ing Pl		27. Manner seath 28a. Date of Injury 28b. Time of 28c. Injury at 1 Living 1 5 ☐ Pending (Month, Day Year) 28b. Time of Injury Work?	28d. Describe how i	njury occurred	
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or At after of Direction by	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,
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To the Hospitel or Attending Physicien: The within 24 hours effer death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, date	and place, and due to	the cause(s)
within To t	Σ	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, I	Day, Year)
1		100 0 30 973		4/28/0	24
5H-3		30. Name in address p rson who completed cause of death (Item 23a) (Type, Print) 31. Pate filed (Month Pau Year) 32. Pate filed (Month Pau Year)	1 2174	C	
S Regis	tate trar	31. Date filed (Month, Day, Year) DEC 3 0 2004 32. Resistrar's Signature			

State of Maryland / Department of Health and Mental Hygiene 42505 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2004 Ashby Ray Jones, Sr. Dec. 9:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1949 Windsor Drive Washington Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 ☐ F 225-34-9018 72 Director 03/06/1932 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ?7 is marked other then "natural", or items 23e or 28a-1 show traumatic event, the Madical Examitter must be notified at 10d. Inside City Limits MD Washington Hagerstown 1 Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 1949 Windsor Drive Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ™Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed with Health and Mental Hygiene. em 27 is marked other ther Senior Master Sargent U S Air Force 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rebecca Harris George Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1949 Windsor Drive, Hagerstown, MD 21740 Katie B. Jones (Wife) other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 🖫 Burial 2 □ Cremation 3 □ Removal from State Rose Hill Cemetery 01/03/2005 Hagerstown, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused it - death. Do not enter the mode of dyin, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on # ch line. Immediate Cause (Final disease or condition resulting in death) **Physician** uedi /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 × No 3 Probably 4 □Unknown 1 🗌 Yes Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 certificate has 1 Yes 2 1 No Attending Physicien: After this certification 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred s after de. •al Director: Ale 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 0 within 24 hours a To the Funeral C 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hind F. Hamdan, M.D.1130 Opal Court, Hagerstown, MD 21740 31. Date filed (Month, Day Year) UEC 3 0 2004 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

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			Ragistrar 1. Decedent's Name (First, Middle, Last)	Tillicate of Death	2. Date of Death		3. Time of Death
	Physicia /Medic		Jean T. Johnson		DECOMBO	Pay Year 2004	1220p M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
4			St. Thomas Moore Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Hyattsville		Prince G	
	Funeral Director		577-44-3145 1 M 2DXF 70 Yrs.	Months Days Hours Min.	June 11	9. Birth Cou. 1934 Wa	place (State or Foreign ntry) Sh.D.C.
7	D		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I				10d. Inside City Limits
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	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. All Hygiene. A chert than "naturel", or items 23a or 28e-f show do other than "naturel", or items 23a or 28e-f show event, the Medical Examinar must be notified at event, the Medical Examinar must be notified at	Funeral Director	7710 Maple Avenue #609	20912		U.S.A.	
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0002	rs afte	by Fi	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify:	lack
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Mary	s 1 and 2 should I Health and Mer Item 27 is marke other treumetic		19a. Informant's Name/Relationship (Type, Print) Rev. Henry E. Johnson-Husband 77.	iling Address (Street and Number or Rura 10 Maple Ave. Tak	i Route Number, C Coma Par	ity or Town, State, Zip ${ m k}$, MD ${ m .}209$	Code) 12
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			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
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	(0 -	e Col	25. Was case referred to medical	CC Plans of Post	1 ☐ Yes 2 ☑		2 No
Vital	ysicien: is certific director,	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	Other		e 6 □Other (Speci	fy)
n of	Attending Physicien: or death. ector: After this certific by the funeral director,		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 28b. Time (Injury (Month, Day Year)	/ Work?	28d. Describe how	injury occurred	
Division	tendii Jeath. tor: A the fu	catio	2 Accident investigation	M 1 Tyes 2 No	28f Location (Street	et and Number or Rur	al Route Number
<u> </u>		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, ractory, onice	City or Town, S	State)	ar rioute rumbor,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.				
	To the within 2 To the complete	Me	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month,	Day, Year)
	70		3Q. Name and address of person who completed cause of death (Item 23a) (Typ	e. Print)	2 00	CEMYOR	67 200y
K			Paul A DE VURE MD 4205QUE	constone Rd Mya	the le	MB 207	81
	Sta Registi		31. Date filed (Month, Day, Year) DEC 2 9 2004 DEC 2 9 2004	ule			

DHMH 17 Rev 1/2001

		1 – For Registrar		epartment of Health and Certificate of Death		2004 L	+2507
	*	Decedent's Name (First, Middle, Last	it)		2. Date of Death		3. Time of Death
Physic		William	Glenn Jett,	.Ir	Month December	Day Year 26, 2004	9:15 A ^M
/Med Exami		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea		4c. County of Death	7,13 11
LXdilli	iic.	39445 Jarrell I	rive	Mechanicsville	9	St. Mary's	
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last birtho			9 Rirthola	ce (State or Foreign
Director		218-38-5641	X M 2 □ F 62 Yrs	s. Months Days Hours Min	June 15.	ear) Country 1942 Washii	
ō.		Usual Residence of Decedent					
nylar how		10a. State 10b. County	10c. City, Town o	r Location		100	d. Inside City Limits
Ba-f s	cto	MD St. Mary	Mechanic	sville			1 □ Yes 2 No
or 26	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Countr	y?
23a	a	39445 Jarrell Dri		20659		U. S. A.	
r deg	Funeral	11. Marital Status	Armed Forces?	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 	Specify Yes or No- rto Rican, etc.)	14. Race - American Black, White, et	
or It	Y.	1 ☐ Never Married 2⊠ Married	1 ⊠ Yes 2 □ No If Yes, Give	1 ☐ Yes 2 ☒ No Specify:		Specify:	
ural'	d by	3 Widowed 4 Divorced	Year or Dates: 166-168	Δ.	5	Whit	
nat nat	Completed	15. Decedent's Ed (Specify only highest gra	de completed) (C	ecedent's Usual Occupation Give kind of work done during most of wo fe. DO NOT use retired)	orking 16	b. Kind of Business/Indu	istry
within sne.	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	· · · · · · · · · · · · · · · · · ·		lutomotivo I	Padr Danai
Hygie III		17. Father's Name (First, Middle, Last)		o Body Repair	me (First, Middle, Ma	Automotive I	зоду керат
portition of a should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked othar than "natural", or Items 23a or 28a-f show any injury or other traumatic avant. It Medical Evantre must be notified at any injury or other traumatic avant.	Be	William Glenn Jet		Mary M	largaret Ro	herts	
d Me	은	19a. Informant's Name/Relationship		lailing Address (Street and Number or F			Code)
d 2 s d 2 s th an 7 ls i		Dawn B. Jett / Wi					
am 27		20a. Method of Disposition	20b. Place of D	45 Jarrell Drive Misposition (Name of	Date 20	LII.C. Mary La c. Location - City or Tow	n, State
Pages nent of h int: If its		1 [™] D*Burial 2 ☐ Cremation 3 ☐	Removal from State cemetery,	crematory or other place) Jan	nuary	21 2	
it. P.; rtme rtant njury		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer 		2 1 2		Cheltenham,	
permit. Departn Imports any inju		21. Signature of Furieral Services ice	1	22. Name and Address of Facility Br	instield-E	Echols Funl.	Hme.,P.A.
		23a Part 1 Enter the disease or com	plications that caused the death. Do not	30195 Three Notch			Approximate
		shock, or heart failure. List only	one cause on each line.		c or respiratory arrest		interval Between Onset and Death
Physician	_	Immediate Cause (Final disease or condition resulting in death)	a metastatic	long Cancer		6	months
/Medical Examiner		resulting in death)	Due to (or as a consequence of)				
		Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of)				
ed sit	iner	cause. Enter Underlying	Due to (or as a consequence or)	•			
ecut and I-tran	Examin	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of)				
icate be executed physician and sthe burial-transit	三田田		240 (0.42 2 20.100423.100 0.)	•			
cate physi	dicai		. d				
w requires that the death certific been signed by the attending p should be detached for use as	Φ	IF FEMALE:	23c. If yes, outcome of pregnancy				
ath o	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of delivery Month D	y Day Year
the g	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)			
hat the deby detac			ontributing to death but not resulting in th	ne underlying cause given in Part I	23e. Did tobac	cco use contribute to the	cause of death?
signe signe	l by			o and onlying datase given in various			bly 4 □Unknown
requir seen si hould	Completed						
as as	nple				24a. Was an autopsy	neige to name	sy findings available pletion of cause of
vical necoviries of the law sertificate has be lirector, page 2 s	Ö				perform 1 Yes 2	death? No 1 ☐ Yes 2	:□ No
cian: cian: ertific	B e	25. Was case referred to medical	H2-d		eath (Check only one)		
Physi this o	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	atient 3 DOA Other. 4 Nursing		e 6 □Other (Specify)	
ing P	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tim	ıry Work?	28d. Dascribe how	injury occurred	
tendi eath or: /	catl	2 Accident investigation 3 Suicide 6 Could not b	9	M 1 Yes 2 No			
or At fiter d	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	City or Town, S	et and Number or Rural I State)	Houte Number,
urs a							
Hosp 24 ho Funs tely fi	edical	(Check only Medical Exer	ysician: To the best of my knowledge, on the basis of examination and/o				
To the Hospital or Attending Physician: The law requires that the death certification of the Funaral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number	204	. Date signed (Month, Da	av Year)
N N S		Last of certified		D 50696			
		030000			De	ecember 27,	2004
20, 21,111	n	·	completed cause of death (Item 23a) (Ty		T		1 20650
THO SAIL	1	Gurdeep S. Ch	nhabra, M.D. 25500	Point Lookout Rd.	Leonardtov	vn, Maryland	1 20030
S Regis	tate trar	31. Date filed (Month DEC 278	2004 32. Plaistrar's Signature	Sparke			

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Arthur Garfield Jamart 14 2004 December 2025 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** THE MEMORIAL HOSPITAL ASTON IALBOT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 01/19/25 9. Birthplace (State or Foreign **Funeral** 1 M 2□ F Maryland 79 Yrs 214-34-7478 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🙀 No MD Talbot Easton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8755 Swann Haven Road 21601 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. filed within 72 hours after Hygiene. 1 Never Married ☐Yes 2☐No Yes, Give X Baltimore, Maryland 21215-0036 1 ☐ Yes 2 № No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Seafood Waterman 11 (Grad) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked other any sijury or other traumatic event, 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Thomas Jamart Julia Hatch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8755 Swann Haven Rd., Easton, MD 21601 Mary Jamart/ Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Donation 5 Other (Specify) Old White Marsh Cemetery 12/18/04 Trappe, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ventricular tackycerdia Physician 20 minuto disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 204000 pronon attey Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 No 1 Probably 4 No 1 Probably 4 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Matural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Direct 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Matthew Finker 052251 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manyland 21601 Matthew Fischer ZMartin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

AMART

			For State Registrer	State of Ma	ryland	-	artment of H		ind Me		ene ()	04	42509
	Physici		1. Decedent's Name (First, Middle, L Valencia A.						1	Date of Death Month Ecember	Day 25,2	004	3. Time of Death 6:12p M
	/Medio Examin		4a. Facility Name (If not institution, g. Frederick Me	ive street and number)	ital		4b. City, Town, or Frederi		f Death		4c. Cour	nty of Death derick	<u> </u>
	Funeral Director			Sex 7. Age	(In yrs. lasi	t birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,	Year) 1930	9. Birthp Cour Wash	place (State or Foreign ntry)
	ט		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation						10d. Inside City Limits
	the Mary 28a-f sh	ector	Maryland Frederi	ick		Fred	erick			10	g. Citizen o	of What Cour	1 ☑ Yes 2 ☐ No
	Sa or	Ö	594 Cawley Drive	e. Unit 3D			21703					d Stat	,
36	be filed within 72 hours after death with the Maryland tal Hygiene. So other than "natural", or Items 23a or 28a-1 show event, the Medical Evanfirst mast be instilled at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces?		ŀ	Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 🔀 No	spanic Orig n, Mexican Specify:	gin? (Specif , Puerto Ric	v Yes or No-	14. R	lace - Americ lack, White,	can Indian,
Maryland 21215-0036	within 72 hou ene. than "natura he Medical E	Completed t	15. Decedent's (Specify only highest g	Education		(Give	dent's Usual Occupa kind of work done of DO NOT use retired,	turing most)	of working	1		Business/In	·
2	e filed within al Hygiene. I other than ' vent, the Me		12	oe)			Homemak		rla Nama /F	First, Middle, M		n Home	3
yland	2 should be fi and Mental H Is marked ot raumatic ever	To Be	17. Father's Name (First, Middle, Last Henry L. Aufdem-	-Brinke				Li	11ian	B. Hod	kinso	n	
Mar	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship		54		ng Address (Street a						
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		Elizabeth J. Dud?	Ley / Daugni	_		Lakeview sition (Name of natory or other place		Pred	erick,		.ana ∠. n - City or To	
OL.	Pages 1 and ment of Healt and title the all ant: If item 2 arry or other		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		ì		natory or other place Cremator	e) I	Decemb 27, 20	Ser F	rodor	ick M	faryland
Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Signature o Funeral Service Lic		Trieu	22	. Name and Addres	s of Facility	Sta	uffer F	unera	1 Home	es, P.A.
110	Priysician		23a. Part1. Enter the disease or co shock, or heart failure. List onl Immediate Cause (Final disease or condition	mplications that caused by one cause on each line	the death.								Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequer	nce of):	130	C 11	1.00	_			
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequer	nce of):	lar	0011	Aps	<u> </u>			
oʻ	ate be executed hysician and the burial-transit	Examiner										<u></u>	
8760,	cate be physici the bu	dical		d									
P.O. Box 6	that the death certificate ed by the attending phys detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 ponths? 1 □ Yes 2 2 No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 🗌 Fetal de	eath 3	Ectopic pregnancy Other (specify)					Date of delive	ery Day Year
	Se un e	by	Part II. Dther significant conditions	contributing to death bu	it not resultin	ng in the ur	nderlying cause give	en in Part I.		23e. Did toba	1		he cause of death?
Records,	The ate his page	Completed								24a. Was an autopsy perform 1 Yes 2	eg!?	prior to cou death?	psy findings available mpletion of cause of
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?						of Death (C	Check only one)		
o	dii ys	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	Hospital: 1 Anpatier 28a. Date of Injury (Month, Day)	y 28	VOutpatien Bb. Time of Injury	28c. Injury Work	at Nur	280	5 🗌 Resider d. Describe hov			γ)
Division	il or Attendation after death	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			e, farm, str	eet, factory, office		28f	Location (Stre City or Town,		mber or Rura	al Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exc	Physician: To the best o eminer: On the basis of and manner stat	examination	edge, death	occurred at the time vestigation, in my op	ie, date and pinion, deat	d place, and th occurred	d due to the cau at the time, dat	ise(s) and i	manner as st	tated. the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier				29c. License	number		29	d. Date sign	ned (Month,	Day, Year)
	(6)		Humas 8.9	Jalone.	MP	•	D003	647	3	1	2-2	45 - 2	1004
	(1)		30. Name and address of person wh	Completed cause of de	eath (Item 20	3a) (Type, DE R	Print) ZV_UEMO	rial t	tosp.	West	DIH	st- F1	REDERICK
	Sta Registi		31. Date filed (Month 12 Cress 8	2004 32. Registra	r's Signatur	0	January 3		,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier [] 42510 1 - For Stete Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Ellen Lillian KEYFAUVER December 28 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year **Funeral** Days Months 1 ☐ M 2 🕱 F 80 215-20-8315 Oct. 4, Director 1924 Mary land Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d toside City Limits 10a State 10b. County 28e-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ANo Director Maryland Washington Sharpsburg 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 5 17539 Snyders Landing Road 21782 USA or Items 23e death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if itam 27 is marked othar than "natural", or Iten any injury or other traumatic event, If a Wedical Exertical any single. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) 12 2 federal government secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Mose Mabel Cramer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17539 Snyders Landing Rd., Sharpsburg, Md. 21782 Ellis L. Keyfauver - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mountain View Cem. 12/31/04 Sharpsburg, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Euneral Service License MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 /irmue Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) Pheciminia Pnysician Days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of listers or in jury that initiated events Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Year Dav 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by t Id be detach Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown enkemis Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has 2 1No 1 Yes Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospitel or Attanding I 24 hours after death. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a a Funeral C 29a. Certifier 1 🖵 🚾 artifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To tha I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 12821_ ()*/KHIT(

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

MO

32. Pegistrar's Signature

IAHEED)

31. Date filed (Month Day Year)

D21457

12-29-2004

AVE. HAGERSTOWN- MD 21749

				State of Ma		Depa	artmen	t of H	ealth a					4251	
			Registrar 1. Decedent's Name (First, Middle, Last)			Cel	rtificat	e or L	Jeath		2. Date of De	Reg. No		3. Time of Dea	
	Physici	an	EMORY BANDON KREIT	FD							Month 12	De 2	y Yeer + 200		
	/Medio Examin		4a. Fecility Name (If not institution, give st				4b. City,	Town, or	Location o	of Death			. County of Dea		
	LXamiii		5794 ARGYLE DRIVE				PARS	ONSBU	JRG				WICOMI	CO	
	Funeral	Г	5. Social Security Number 6. Sex	7. Ag	e (in yrs. last t	birthday) Yrs.	If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of Bir (Month, Da 05-27-1	h y Year)	9. Bir	thplace (State or Fo	reign
U	Director		577-24-4956 LSual Residence of Decedent		84	113.					05-27-1	920	WAS	HINGTON, D	
	death with the Maryland ms 23e or 28a-f show finast be notified at		10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside City Li	
	Ba-fs	Director	MD WICOMICO		PAR	RONS	SPURG							1 ☐ Yes 2\(\)]No
	with th	Dire	10e. Street and Number				10f. Zip		21849			10g. Cit	izen of What Co USA	ountry?	
	eath ve 23	Funeral	5794 AGRYLE DRIVE	2. Was Decedent I	Ever in U.S.	13	Was Decer			nin? (Spe	ocify Yes or No		14. Rece - Am	erican Indian.	
٥	after d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ N						, Puerto	ecify Yes or No Rican, etc.)		Black, Whi	te, etc.	
12-0030	d within 72 hours after death with the Marylan piene. I then "natural", or Items 23e or 28a-1 show Ite Medical Exacilier mat be notified at	d by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	ARMY		1 🗆 Yes	X□ No	Specify:				Specify: W	HITE	
ה	"natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16	(Give	dent's Usua kind of wo DO NOT us	rk done a	luring most	t of worki	ng	16b. K	ind of Business	Andustry	
717	within 72 iene. than "nai	omp	Elementary/Secondary (0-12)	College (1-4or 5	(+)		ECTRI		,				ELECTR	ICAL	
0	The Hyge	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)		
yland	A = B ●	ToE	ROBERT EMORY PATTE	RSON KRE	ITER _				LETI	TIA	COCKREI	L			
Mar	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Typ				_					-	or Town, State,		
a)	1 and Healtl em 27 ther t		ROBERT EMORY KREIT 20a. Method of Disposition	ER - SON	20b. Place	of Dispo	sition (Nar	ne of	- 1		UNSBUKG Pate		RYLAND ocation - City or		
DE L	ages ant of it; if it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemet	tery, crer	natory or o	ther place		2-28	-2004		MAR, DE		
Baltimol	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licenses		CKLINA	_							L HOME,		
ñ	permi Depa Impo any ir		Cent I la	mut										YLAND 218	04
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused cause on each lir	the death. Do	o not ent	er the mod	e of dying	g, such as	cardiac c	r respiratory a	rest,		Approximate Interval Between	
	Physician	_	Immediate Cause (Final disease or condition resulting in death)	Asperat	in Pre	Man	in							Onset and Deat	11
	/Medical Examiner		resulting in dealin)	Due to (or as	a consequenc	e of):	1, 4								
	Đ.	ler	Sequentially list conditions, b.	Due to (or as	a consequence	= 14 Co	Clack								
	cuted	Examiner	lary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
/on,	be executed ician and burial-transit	Ex	resulting in death) Last	Due to (or as	a consequenc	e of):									
2/20	0 0	dlcai	d.										-		
DOX C	certifical nding phy use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome									23d. Date of de	livery	
ă	the death y the atter sched for u	Iclai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at]Ectopic pr] Other (sp						Month	Day Year	
r Ö	at the I by th	Phys	9 Unknown	9□ Unknown											
S,	The law requires that ite has been signed b oage 2 should be deta	by	Part II. Other significant conditions cont	ributing to death bi	ut not resulting	j in the u	nderlying c	ause give	ın in Part I.		4			the cause of death obably 4 20 Unkn	
cords	requi	eted									24a. Was				
ě	sician: The law certificate has t irector, page 2 s	ompleted			-						autop	rmed?	death?	utopsy findings avail completion of cause	a of
Vital		C	25. Was case referred to medical						26 Place	of Death	1 Yes		1 L Yes	2 □ No	
	Physician: this certific al director,	To B	examiner? 1 ☐ Yes 2 ☑No	ospital: 1 🗆 Inpatie	nt 2 ER/C	Dutpatien	t 3 DC	A Othe					6 ☐Other (Spe	cify)	
IO U	ing Pt		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Da)	y Year) 28b	. Time of Injury		8c. Injury Work			28d. Describe I	ow injur	y occurred		
DIVISION	death.	cat	2 Accident investigation 3 Suicide 6 Could not be	20a Blood of Init	ini. At home	form sta	M		/es 2 □ N		39f Location //	trant on	d Number of C	usel Pauta Numbes	
2	after Direct Jin by	Certification;	4 Homicide determined	28e. Place of Inju- building, etc	c. (Specify)	rarm, str	eet, ractory	, office		•	City or Tov	m, State)	ural Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, to	edical C	29a. Certifier Certifying Physic (Check only 2 Medical Examine	ician: To the best of	of my knowled	ge, death	n occurred	at the tim	e, date and	d place, a	and due to the	cause(s)	and manner as	s stated.	
	thin 24 the F	Medi	one) 29b. Signature and title of certifier	and manner sta	ited.			. License					te signed (Mont		
	5 4 K 5		1 1 s na) <i>00</i> 1130					27/04		
	a Sign		30. Name and address of person who com	npleted cause of d	eath (Item 23a) (Type,	Print)			-					
	190		JANE A GIM	, mo 560	Giversite	· D.	. Sai	ta A	204	Suls	buy Me	21	801		
	Sta Registr		31. Date filed (Month, Day Year) 7 20	32. Registra	ar's Signature	19	A	oak	2						
	•														

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 2 8 2004

ORIGINAL

32. Registrar's Signature

Physicia /Medic **Examin**

Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinating the notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Longanecker Plea	se Type or Prir	nt in Black In	delible lnk. E	nsure All	Copies A	re Legible.	
1 - For State Registrar	State of Ma		artment of Hea rtificate of De		-	200 L	42513
1. Decedent's Name (First, Middle	e, Last)			2	2. Date of Death	Day Yeer	3. Time of Death
Curtis Jay L	onganecker]	Month December	0= 00=1	1544 р м
4a. Facility Name (If not institution Frederick Memo		1	4b. City, Town, or Loc Frederic			4c. County of Dea Frederi	
5. Social Security Number 213–68–6993	6. Sex. 7. Agr 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e (In yrs. last birthday) 49 Yrs.		ours Min.	Date of Birth (Month, Day, Y Ctober 1	9. Bin 9 1955 M E	thplace (State or Foreign ountry) aryland
Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
Tou. State		100. Only, Town of Ec	Joanon				1 Yes 2 XNo
	ington	Ha	agerstown				10163 2 1
10e. Street and Number	O T OCH		10f. Zip Code		10g	. Citizen of What Co	ountry?
13300 Salem (Church Road		2174	0		U.S.1	A.
11. Marital Status 1 □ Never Married 2 ★ Mar	12. Was Decedent Armed Forces?		Was Decedent of Hispa If Yes, specify Cuban, M	nic Origin? (Spec lexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	
3 Widowed 4 Divorced	If Yes, Give		1 ☐ Yes 2 🔀 No S	oecity:		Specify: W	iite
15. Deceder (Specify only highe	t's Education st grade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	n g most of working	16	b. Kind of Business	/Industry
Elementary/Secondary (0-12)	College (1-4or 5	o+)	pervisor			Utility	Company
12 17. Father's Name (First, Middle,	/ A)			Mother's Name (P**		Company
19a. Informant's Name/Relations Michelle Jane 20a. Method of Disposition 1	Longanecker 3 Removal from State	(wife) 13 20b. Place of Disponsional Commetery, creations of the commetery of the commetery of the commetery of the commetery of the commeter	ng Address (Street and 3300 Salem (position (Name of matory or other place) rg Cremator	Church R	d Hagers	town Mary	land 21740
21. Signature of Funeral Service	Licensee		2. Name and Address of				
// Muda	1 111	re 1	331 Eastern	n Blvd. 1	N. Hager	stown Mar	yland 2174
23a. Part1. Enter the sease, o shock, or heart ailure. List Immediate Cause (Final disease or condition	r complications that cause only one cause on each lin	the death. Do not ent	ter the mode of dying, so	uch as cardiac or	respiratory arrest	,	Approximate Interval Between Onset and Death
resulting in death)	a. Due to (or as	a consequence of):	prince	V		1	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b.CCLTE	a consequence of):	LISSUN	m wa	n rup.	ruse sulsaise	
Cause (Disease or injury that initiated events resulting in death) Last	chype to (or as	e consequence of):	theroscl	erotic	sduce	xuldisa	SL-
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year
Part II. Other significant conditi	ons contributing to death b	ut not resulting in the u	enderlying cause given in	Part I.			the cause of death?
					24a. Was an autopsy performe	24b. Were au prior to death?	stopsy findings available completion of cause of

Examiner within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed

Physician /Medical

> 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 27. Manner of Death

1 Natural

2 Accident

31. Date filed (Month Pay (103)

Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation

6 Could not be determined

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

Medicai Certification: To Be

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signatore and title of certifier

OCME

29d. Date signed (Month, Day, Year)

December 28, 2004

death (Item 23a) (Type, Print)

11 Penn Street, Baltimore, MD 21201

SH-S State Registrar

32. Registrar's Signature

			1- State of Maryland / D		rtment of He		and M		giene	004	42514
	•	4	Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
	Physici /Medic		Geraldine Ardell Leveillee					Dec. 2	5. Da	ž004 ^{Ye} a	2:30 P M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation o	of Death			County of De	
	7.86	Ů.	Southern Maryland Hospital		Clintor				P	rince	George's
n	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 69	rthday) Yrs.	If Under 1 Year Months Days	Hours 1	Min.	8. Date of Birt (Month, Da 04-01-	h v, Year) 1025	9. 6	Birthplace (State or Foreign Country)
			226-44-1892					04-01-	1935) V	irginia
	how		10a. State 10b. County 10c. City, Town	m or Loc	ation						10d. Inside City Limits
	e Ma	ctor	MD Charles Walde	orf							1 ☐ Yes 2 No
	ith th	Dire	10e. Street and Number		10f. Zip Code					tizen of What	Country?
	s 23e	eral	7017 Evergreen Drive	10.11	20601		1.0.10			I.S.A.	
36	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23s or 28s-f show any injury or other traumatic avant. The Medical Examinat must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	lf.	Vas Decedent of His Yes, specify Cuban ☐ Yes 2 X No	panic Orig , Mexican Specify:	gin? (Spec I, Puerto F	cify Yes or No Rican, etc.)		Black, W	merican Indian, hite, etc. White
21215-0036	2 hou	ted	15. Decedent's Education 16a.	Deced	ent's Usual Occupat	ion			16b. K	ind of Busine	
2	ithin 7 19.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. D	kind of work done du OO NOT use retired)	iring most	of workin	ig .			
2	ed wi ygien ygien nar th	Con	12	Sup	ervisor					etail	
Maryland	i be fi	Be	17. Father's Name (First, Middle, Last) Davis Winston Gibson		1			(First, Middle, Shiffle		Sumame)	
2	should ad Me mark matic	T _o		Mailin	g Address (Street an					or Tourn State	Zin Cada)
	nd 2 sulth ar				Evergreen						
altimore,	s 1 ar		20a. Method of Disposition 20b. Place of		sition (Name of atory or other place)			ate			or Town, State
Ē	Page nent o int; If iry or		- A suriar a distinction of the suriar state		em. Garder		-30-	2004	Wal	dorf,	MD
a	rmit. spartn sports y inju		21. Signature of Funeral Service Licensee M01246	22	Name and Address	of Facility	v			,	
<u> </u>	20 = 9 9		Nach A. Wilson		luntt Fung P.O. Box	156,	Wald	orf, M	2	0604	
			23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	not ente	r the mode of dying,	such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)								Onioo, and Doam
	Examiner		Due to (br as a consequence of	of):							
	3.	Jer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	(at)e	/ /	5	1				
	cuted nd ransit	Examiner	that initiated events	el	Vascul	W	1/15	eare			
Ó,	e exerian ar	Ex	resulting in death) Last Due to (or as a consequence of	of):	Avles	0.7					
8760	cate be executed physician and the burial-transit	dical	d_ lownar	7_	ZITTOU	1/15	eas	L	_		
9		/Mec	IF FEMALE:								
Вох	death certifi e attending d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? State Calculum 23c. If yes, outcome of pregnancy 1		Ectopic pregnancy Other (specify)					23d. Date of d Month	lelivery Day Year
o.		ysi	1 Yes 2 No 9 Unknown 9 Unknown	30	Ottier (specify)						
ري ت	law requires that the death certif as been signed by the attending 2 should be detached for use a:	by PI	Part II. Other significant conditions contributing to death but not resulting in	n the un	derlying cause given	in Part I.		23e. Did to	bacco u	ise contribute	to the cause of death?
Records,	w require been sig should b		MIDDM, Hypertension,	16	spl) or	1 HC	>	1 □ Y	es 2	Z(No 3□	Probably 4 Dunknown
ဝင္ပ	e law re has be je 2 sho	Completed						24a. Was a		24b. Were	autopsy findings available
	Th ete pag	Com						perfor	med? 2000	death	o completion of cause of es 2 \sum No
Vital	cian: ertific	Be	25. Was case referred to medical examiner?			26. Place	of Death	(Check only or	18)		
	Physician: The la r this certificete has ral director, page 2	To	1 ☐ Yes 24 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Out 27. Manner of Death 28a. Date of Injury 28b. T			0.000		e 5 Resid			pecify)
u O	ding h. After funer	tlon	1 Natural 5 Pending (Month, Day Year) In	Time of Injury	28c. Injury a Work? M 1 7e	ıtı ıs 2∐N		3d. Describe h	ow injur	y occurred	
Division of	al or Attandii s after death. I Diractor: A d in by the fu	ifica	3 Suicide 6 Could not be	ırm, stre				3f. Location (S	treet an	d Number or I	Rural Route Number,
á	s afte	Certification:	4 Homicide building, etc. (Specify)					City or Tow	n, State)	
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and manner stated.	death	occurred at the time, estigation, in my opin	date and	i place, ar h occurred	nd due to the o	ause(s) ate and	and manner a place, and di	as stated. ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and little of certifier		29c. License r	number		2	9d. Dat	e signed (Moi	nth, Day, Year)
-)(C)		-14 DOO	532	19		12/	36/2	2004
			30. Name and address of person who completed cause of death (Item 23a) ((Туре, Р	rint) O -	102		0 1	1	10	2 ") '
M	1P 5		LACAR A. HNSARI, MD	(!	E rusi C	14	4	hend	1h	Y+LI) OX	EMI) 20605
8	Sta Registr		31. Date filed (Month, Day, Year) 32. Regulars's Signature DEC 2 8 2004	. 4	Soule				l		

		1 - State Registrar	e of Maryland / De <i>C</i>	partment of Fertificate of			giene Reg. No. 20 (04 42515
Physicia	an	1. Decedent's Name (First, Middle, Last)		Long		2. Date of De Month	ath Day	3. Time of Death
/Medic	al	Irene D. 4a. Facility Name (If not institution, give street and	number)	Long 4b. City, Town, o	r Location of Death	12	4c. County of	
	4	FUNIASAIA KLG/ONOM ME 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	SAU	If Under 24 Hrs.	8. Date of Bir		9. Birtholace (State or Foreign
Funeral Director		077-18-9395 1□ M 2X		Months Days	Hours Min.	8. Date of Bir (Month, Da October	20, 1923 B	9. Birthplace (State or Foreign Country) rooklyn, New York
yland		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	r Location				10d. Inside City Limits
the Mar 28a-1 si	Director	Delaware Sussex 10e. Street and Number	Lewes	10f. Zip Code			10g. Citizen of Wh	1 Yes 2XXVo
h with t	al Dir	34475 Carpenter Circl	e	1995	8			tes of America
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 Is marked other than "natural", or Items 23e or 28e-1 show any injury or other treumatic event, the Medical Exam car must be routiled at anone.	d by Funeral	1 Never Married 2 Married 1 Nover Married 2 Married 1 Nover Ma	d Forces? Yes 2 No 1942- s, Give or Dates: 1944	1 ☐ Yes 2 🗶 No	an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Black Specify:	- American Indian, , White, etc. White
215-(Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Coile	ted) 16a. De (G	ecedent's Usual Occup Rive kind of work done 'e. DO NOT use retire	pation during most of work d)	ing	16b. Kind of Bus	
212 led with tygiene nt, the		12 17. Father's Name (First, Middle, Last)	Hor	memaker	18 Mother's Name	- (Eiret Middle	In Her	Own Home
lanc	To Be	Casimir Dua	rt		Deolinda	s (1 list, Middle		Periera
Mary 12 shou h and M 7 Is ma		19a. Informant's Name/Relationship (Type, Print, Mr. Joseph M. Haney (S		ailing Address (Street 75 Carpent				
or the property of Health		20a. Method of Disposition	20b. Place of Di	isposition (Name of crematory or other pla				City or Town, State
Baltimore, sermit. Pages 1 a pagent a moreont of Hea moreont: If them on your othe sone.		1 ☐ Burial 2 【**Cremation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify)	rom State	brook Cremat	tory 30,	2004	Wilmingt	on, Delaware
Ball permit Depar Impor		21. Signature of Funeral Service Licensee	also)	Hicks Home	for Fune	rals, F	A. kton Ma	ryland 21921
18760, cate be executed Examiner physician and the burial-transit the burial-transit	dical Examiner	Esquentially list our difference if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiliated events c.	hat caused the death. Do not	enter the mode of dyin	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
5. Box 6 D. Box 6 In death certification of the attending hed for use as	Physiclan/Med	in the past 12 months?	s, outcome of pregnancy live birth 2 ☐ Fetal death Pregnant at time of death Joknown	3 □Ectopic pregnance 5 □ Other (specify) _	у		23d. Date Mont	of delivery th Day Year
cords, P.O wrequires that the been signed by th	by	Part II. Other significant conditions contributing	to death but not resulting in th	ne underlying cause gr	ven in Part I.		obacco use contrib	bute to the cause of death?
cord	Completed	Carlshor Dilla	1	n. seu		24a. Was	an 24b. W	ere autopsy findings available for to completion of cause of sath? Yes 2 \(\subseteq \text{No} \)
of Vital F Physicien: The this certificate	Be	25. Was case referred to medical examiner? Hospital:		Ott	26. Place of Deat			
Phy Prhy rathis	n: To	27. Manner of Death 28a. I	1 Inpatient 2 ☐ ER/Outpa Date of Injury (Month, Day Year) 28b. Tim Inju	ne of 28c. Inju	4 IAMISHING III		dence 6 Other how injury occurre	
Division To the Hospitel or Attending within 24 hours elter death. To the Funerel Director: After	Certification:	2 Accident investigation	Place of Injury - At home, farm building, etc. (Specify)	M 1	Yes 2 No	28f. Location (City or To	Street and Number wn, State)	r or Rural Route Number,
Hospite 14 hours Funerel	edical C	(Check only 2 Medical Examiner: On	o the best of my knowledge, d					
To the I within 2 To the Complet	Med	one) and 29b. Signature and title of certifier	manner stated.	29c. Licens	se number		29d. Date signed	(Month, Day, Year)
		1		1	MOUN		1212	MIN
10		30. Name and address of person who completed STEVEN HEARNE, M		PROIL ST.	SALISB	und me)	
Sta Regist		31. Date filed (Month, Day, Year) DEC 2.9 2004	32. Registrar's Signature			,		

	-	For Stete Registrar	State	of Maryla		rtment of F			gie <u>pe</u> () (_}	42516
		Decedent's Name (First, Middle,	Last)					2. Date of Dea	ath	3. Time of Death
Physicial		Inga Alic	e Lesn	icv				Decembe		9er 04 4:10 P M
/Medica Examine		4a. Facility Name (If not institution,				4b. City, Town, o	r Location of Death		4c. County of [
		Northampton Ma	nor Heal	th Car	e	Freder			Frede	
Funeral Director		5. Social Security Number 082-03-7345	i.Sex 1 □ M 2 X F	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Day Nov. 16	y, Year) 9.	Birthplace (State or Foreign Country) Sweden
P.		Usual Residence of Decedent								T
arylar ehow	_	10a. State 10b. County		10c. (City, Town or Lo	cation				10d. Inside City Limits 17 Yes 2 □ No
8a-1	Director	Maryland Frede	rick		Frederio	1			40 - 000	
with the	<u>-</u>	10e. Street and Number				10f. Zip Code	100		10g. Citizen of Wha	
eath	e a	1421 Taney Ave		edent Ever in	U.S. 13. V	Vas Decedent of H		ecify Yes or No-		States American Indian,
fter d	Funeral	1 ☐ Never Married 2 ☐ Married	Armed F d 1 ☐ Yes	orces? 2 ☑ No			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		White, etc.
all, o	2	3	If Yes, G Year or I	ive		∏ Yes 2√ No	Specify:		Specify:	White
72 ho	Completed	15. Decedent's (Specify only highest)	16a. Deced	lent's Usual Occup	ation during most of work	ina	16b. Kind of Busin	ess/Industry
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lled w dygie her ti		11. Father's Name (First, Middle, La	ect)		Lec	ensea Be	autician	a /First Middle	Beauty S Maiden Sumame)	baloon
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Dattillorey IN permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tre	ľ	20a. Method of Disposition		20b	Place of Dispo			Date	20c. Location - Cit	
Defitilition Sermit. Pages Department of mportant: If it is any injury or one.		1 ☐ Burial 2 反 Cremation 3 1 ☐ Donation 5 ☐ Other (Spe			•	Cremato		3/2004	Frederick	.Maryland
Dalti permit. Departir Importa any inju once.	Ī	21. Signature of Funeral Service Li	censee	1		. Name and Addre				Homes, P.A.
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Physician		Immediate Cause (Final disease or condition	a.	au	ite no	your	dial i	yaut	202,	Onset and Death
/Medical Examiner		resulting in death)	Due to	(or as a cons	equence of):	1		0		
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th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or 1☐Live	utcome of preg birth 2 - Fe	nancy etal death 3	Ectopic pregnancy	/		23d. Date of Month	f delivery Day Year
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ding Ph h. After th funeral	o U	27. Manner of Death 1 ☐ Natural 5 ☐ Pending		nth, Day Year)	28b. Time of Injury	28c, Injur Wor M 1	yat k? Yes 2 □ No	280. Describe r	now injury occurred	
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Balor A safter of Director by	Certification:	4 Homicide determin		ding, etc. (Spe		55, watery, 51105		City or Tox	vn, State)	,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical		xeminer: On the						cause(s) and manne date and place, and	
To the within To the comp	×	29b. Signature and title of certifier	0/	mah		29c. Licens	e number	7;	29d. Date signed (A	fonth, Day, Year)
		>	#2/	MD.			0746	00	12-22	2004
ļ		30. Name and address of person w	ho completed cau	use of death (It	em 23a) (Type,	Print)	/\.	PEN	double	NIN DIANI
		31. Date filed (Month Pay Year)	1946	Registrar's Sig	nature a	itcia	ITE MY	CHI	CKICK	170 21101
Stat Registra		DEC 2	8 2004	To Beaga	M. A	mark.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Рм 12-22-2004 FLORENCE LOUISE LOCKHART 12:10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death LARKIN CHASE NURSING HOME PRINCE GEORGES BOWIE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 07/25/1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 💢 F 90 WEST VIRGINIA 236-01-6610 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 27 No MARYLAND WORCESTER SNOW HILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3514 TALL PINES LANE 21863 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify Specify: 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry DEPARTMENT OF Elementary/Secondary (0-12) College (1-4or 5+) AGRICULTURE **EXECUTIVE SECRETARY** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HUGH PEYTON ELIZABETH SIX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GARY N. LOCKHART/ SON 3514 TALL PINES LANE SNOW HILL, MARYLAND 21863 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Cemetery Crematory or other place)
ARLINGTON 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) CEMETERY 01/03/2005 ARLINGTON, VIRGINIA
22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME NATIONAL ČĒMĒTERY 21. Signature of Funeral Service Licensee 16000 ANNAPOLIS ROAD BOWIE, MARYLAND 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23d. Date of delivery Month Year Day use contribute to the cause of death? 2 □ No 3 □ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

29d. Date signed (Month, Day, Year)

12-23-04

Physician /Medical Examiner

burial-transi

permit. Page Department of Importent: If any injury or once.

Physician

/Medical

Examiner

Funeral Director

Be Completed by

2

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any or other treumatic event, the Modical Examinar must be notified at

Baltimore, Maryland 21215-0036

Hospitel or Attending Physicien: The law requires that the death certificate be executed

after death.

within 24 hours a
To the Funerel C

filled in by

Division of Vital Records, P.O. Box 68760,

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	Examiner	
	by Physician/Medical	
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	Immediate Cause (Final disease or condition	PNEUMONIA			Onset and Dea
	resulting in death)	Due to (or as a consequence of	:		
by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter underlying that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequenc			
ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2X No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Yea
ed by Ph	Part II. Other significant conditions of CEREBROVASCULAR	contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco u 1 ☐ Yes 2	use contribute to the cause of deat
Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 X No	24b. Were autopsy findings ava prior to completion of caus death? 1 \(\text{Yes} \) 2 \(\text{No} \) No
ø	25. Was case referred to medical		26. Place of D	eath (Check only one)	1
To B	examiner? 1 ☐ Yes 2 XNo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA Other: 4X Nursing	Home 5 Residence	6 □Other (Specify)
	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Tin	ne of 28c. Injury at	28d. Describe how injur	y occurred
Sertific	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
Medical Certification:		ysician: To the best of my knowledge, oniner: On the basis of examination and/and manner stated.			
Me	29h Signature and title of certifier		29c. License number	29d. Dat	te signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) DEC 27 2004

29b. Signature and title of cert



30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Neelam Ashai, 4410 74th Avenue, Landover, MD 20784

29c. License number

D48213

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Gerard Lloyd, Sr. 4:00a [™] December 23, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 988 Duvall Highway Pasadena If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Feb. 18, 1947 Anne Arundel 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 □ F Hours 217-46-4375 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. worle 10c. City, Town or Location 10d. Inside City Limits oriant: If item 27 is marked other than "netural", or items 23e or 28e-1 shov injury or other traumatic event, it c Modical Examitter must be notified at 1 ☐ Yes 2√ No Director MD Anne Arundel Pasadena 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 988 Duvall Hwy. 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Goodmann's Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Lloyd Edna Allen ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Lloyd/Wife 988 Duvall Hwy, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. 28 2004 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, MD permit. Page Department of Importent: If any injury or once. MD Veterans Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Barrancodo & Sons, P.A. Severna Park Funeral Home 4 nomes 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician metastanc disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 🗆 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death neral Diractor: After th filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D21613 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8096 Edwin Raynox Blud. Suite Pasadena, MD 21122 MD Dailey 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 2 7-2004

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 105 OAM **Physician** John Murray Kenneth Jr. December 23, 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Hours | Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 3 M 2 □ F Maryland December 23 2004 Yrs. NONE Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other then "natural", or liema 23a or 28a-f show traumatic event, tra Medical Examinar must be multified at 1 Yes 2 0 Marlboro Maryland Prince Georges Director) pper 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20772 11002 Rhodenda Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status within 72 hours after 1 ☐ Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Biack If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NONC NONC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be and Mental I Kenneth Murray John Vonne JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Murran ather Ave upper Marlboom Md 20772 11002 Rhoderda If itam 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 0 Harmony Memorial Park/2/30/04 permit. Page Department of Important: If any injury or once. Name and Address of Facility 21. Signature of Funeral Service Lice 020 ound 38 Marlboro 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Extreme Fetal SSMin Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate the first local sequence of the conditions Due to (or as a consequence of) Examine physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 N 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 🗆 No 1 🗌 Yes 2/No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📆 Oo 1 Propatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🞏 🕰 artifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier D39708 who completed cause of death (Item 2 a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)
DEC 2 9 2004

North Hanson Court (#304) Bowie Maryland, 20716
2 9 2004

Lean & Sperle

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			For State Ragistrar	Olulo 0	i marytari	•	rtificate of		_	Reg. No.	2004	42520
			Decedent's Name (First, Middle,	Last)					2. Date of De		Year	3. Time of Death
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	Examin		4a. Facility Name (If not institution,					or Location of Death	1		County of Death	'oomaoa
			Malcolm Grow 5. Social Security Number	Medical	Cente		-	Springs If Under 24 Hrs.	8 Date of Bir		rince G	
	Funeral Director	Ì		1 <mark>22</mark> M 2□F		7 Yrs.	Months Days		8. Date of Bir (Month, Da	y, Year)	S - C	place (State or Foreign htry)
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	show det	_	10a. State 10b. County		10c. City	, Town or Lo	ocation				1	0d. Inside City Limits 1 Yes 2 □ No
	he M	Director	MD P.G. 10e. Street and Number		F	t. Wa	shingto	nn		10g Citiz	en of What Cour	
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	ma 23	Funeral	11. Marital Status		edent Ever in U.	S. 13.	Was Decedent of	Hispanic Origin? (S pan, Mexican, Puerl	pecify Yes or No	j- 1-	4. Race - Americ Black, White,	can Indian,
9	or Ite		1 ☐ Never Married 2 ☑ Marrie		2 XNo		1 ☐ Yes 2 ☐xNo		o moan, etc.,		Specify: Bla	
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	of Health of Health item 27		Carol McCaule: 20a. Method of Disposition	y/wife	20b. P	lace of Dispo	osition (Name of matory or other pla		Date Date		asn.MD.	
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Baltimore,	permit. Page Department Important: If any injury o		21. Signature of Funeral Service L	icensee		2	2. Name and Addr	ess of Facility	Hodges	and	Edward	ls
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la	ician: Th certificate rector, pag	e Co	25. Was case referred to medical					26 Place of De	1 ☐ Yes ath (Check only		1 🗆 Yes	2∐ No
Ž	Physicia this cert al direct	To Be	examiner? 1 □ Yes 2 1 No	Hospital: 1	Inpatient 2	K FVOutpatie	nt 3□ DOA O	then	lome 5 ☐ Resi		□Other (Specif	(y)
0 0	Attending Physician: If death. ector: After this certifics by the funeral director, I		27. Manner of Death 1. Matural 5 □ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury	W		28d. Describe	how injury	occurred	
sio	death. ctor: A the fu	catl	2 Accident investig	ation]Yes 2 □No	29f Logation	Street and	Alumbos os Gue	al Route Number,
Division of Vital Records,	l or Attendater deatl	Certification:	4 ☐ Homicide determi	nod 200. Flac	e of injury - At no ling, etc. (Specif	by)	treet, factory, office	•		wn, State)		ar Addie Namber,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ai C						time, date and place				
	he Ho in 24 I he Fu pletel	Medical	(Check only 2 Medical one)		nner stated.	ation and/or in		opinion, death occi	urred at the time,			
	To t To t	Σ	29b. Signatore and title of certifier	A 1 1 A	4.		29c. Licer	nse number		29d. Date	signed (Month,	Day, Year)
D	(10)		Jank	1. W.W.	an.~	<u> </u>	DA	10/6		14	70104	G _E
3 K	(10)		30. Name and address of person	who completed cau	ise of death (Iter	n 23a) (Type	Print)	nd Fl	Suitla.	220	ma =	40)46
	St	ate	31. Date filed (Month, Day, Year)	32	Registrar's Signa	ature	-	, ,	. 11-0		,	
	Regist		DEC 2 9 2	2004	Land &	1 60	we					

DHMH 17 Rev 1/2001

		4	For State of Maryland / Dep Registrer Ce	artment of Health and Mertificate of Death	lental Hygien	フロロム センケント							
		Ng	. Decedent's Name (First, Middle, Last)		2. Date of Death Month D	3. Time of Death							
	Physicia	-	Martha Louise Mackey		December 3	/\ \A							
	/Medic Examin		a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death							
		A	Southern Maryland Hospital	Clinton		Prince George's							
7	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	Birthplace (State or Foreign Country)							
	Director		264-72-0975 62		May 31, 19	942 Clearmont, FL.							
	and	-	Usual Residence of Decedent 10c. City, Town or L 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits							
	f aho	ō	MD Prince George's Clinton			1 ∰Yes 2 ☐ No							
	the the 28a-	Director	10e, Street and Number	10f. Zip Code	10g. C	Citizen of What Country?							
	with with		9211 Stuart Lane	20735		USA							
	filed within 72 hours after death with the Maryland Hygiene. Uther than "natural", or Items 23a or 28a-f ahow ent, the Madical Examinal must be matthad an	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13.	. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,							
۵	or iter	Für	Armed Forces? 1 Never Married 2 Married I Yes, Give	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	rican, etc.)	Black, White, etc.							
2	ours a	l by	3 Widowed 4 Divorced Year or Dates:	To Tes Zaxio Specify.		Specify: Black							
Maryland 21215-0036	72 h	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ing 16b.	Kind of Business/Industry							
2	vithin ne. han '	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		Determine							
7	iled v Hygie her t		12th Hot 17. Father's Name (First, Middle, Last)	ısekeeper	e (First, Middle, Maide	Private							
anc	t be f ntal h ed of	Be	Griffin Keys	Maude S	•	,							
2	houk d Me mark matic	유		ling Address (Street and Number or Rur		or Town, State, Zip Code)							
<u>8</u>	od 2 s lith ar 27 is 27 is			31st Ave. Temple									
ō,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f ahow may injury or other traumatic event, the Modical Examinar must be natified any injury or other traumatic event, the Modical Examinar must be natified any injury or other traumatic event.		20a. Method of Disposition 20b. Place of Disposition	position (Name of ematory or other place)	Date 20c.	Location - City or Town, State							
E	Page ent o nt: ff ry or		1 № Burial 2 U Cremation 3 U Removal from State	tion Cemetery Dec.	30,2004 C1	inton, MD							
Baltimore,	mit. partm sorta / inju					enkins Funeral Home							
Ö	Departing any ir		Delra Golden	716 Kennedy St. NW	Washingto	n, DC 20011							
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between										
	Physician		Immediate Cause (Final disease or condition	Antery Dis		Onset and Death							
	/Medical		resulting in death) Due to (or as a consequence of):										
	Examiner		Sequentially list conditions, b. () in he fel										
	pe sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
	and and I-tran	Examiner	resulting in death) Last C. Compare Constitution Compare Cons										
8760,	death certificate be executed e attending physician and of for use as the burial-transit	E E											
687	icate phys s the	edicai	d										
×o	leath certific attending p	J/M	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery							
\mathbf{m}	death a atter	Physician/Me	in the past 12 months? 1 Vec. 3 No. 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year							
o.	the che	hys	9 ☐ Unknown										
ري ص	requires that been signed b hould be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?							
ğ	w require been sig should b				1 🗆 Yes	2 [™] No 3 Probably 4 Unknown							
ecords,	aw 2 s	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of							
α	i: The licate har.	mo:			performed′ 1 ☐ Yes 24☐								
Viital	yaiclan: is certific director.	Be (25. Was case referred to medical examiner?		th (Check only one)								
Ž	C	2	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 🛣 EP/Outpati			6 ☐ Other (Specify)							
D C	ing P	ion	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how in	july occurred							
Sic	Attending r death. ector: Afte by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		28f. Location (Street	and Number or Rural Route Number,							
Division of	Dir	Certification:	determined determined determined determined determined 286. Place of injury - At nome, farm, inju	stroot, radioly, office	City or Town, St.								
_	pour lere	aiC	29a. Certifier 1≅ Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place	and due to the cause	o(s) and manner as stated.							
	To the Hos within 24 h To the Fun completely	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu									
	To the Vithin 2 To the Complet	Ž	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)							
)	9		· Muy /real	100059478	- 1)ec	ember 23 2004							
	OC.		30. Name and address of person who completed cause of death (Item 23a) (Typ	Print)	01.1	embre 23 2004 M.D 20735							
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	xirrappe KC	Clinton	111111 3073							
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December 23, 2004 51.	ime of Death
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Director	State or Foreign
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(Month, Day Year) Injury Work?	spice
2 Accident investigation M 1 Yes 2 No Solicide Solicide 6 Could not be determined determined by the related to the solicide of the solicide o	
determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Rout	
Description of the property o	Number,
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only (Ch	
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)	
29c. License number 29d. Date signed (Month, Day, Y	ar)
10 Clast 12/23/0	t
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
Charles Harrison, M.D. 6001 Muncaster Mill Rd., Rockville, MD 20855	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	

State of Maryland / Department of Health and Mental Hygipne 0 4 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2004 Sarah Lewis McMillan 21 Dec /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Montgomery Spring
| If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday)
56 vrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 XF March 9,1948 Director 578-66-1515 Clarksburg, Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 XYes 2 ☐ No Directo MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? e filed within 72 hours after death with tal Hygiene. 3524 Peartree Court #14 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: African If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced American 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Entrepreneur Tax Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H lant: If itam 27 is marked ot Be Lloyd Richard Lewis Geneva Paden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leon Hollowell/Son 14009 Castle Blvd, #14 Silver Spring, MD 20904 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury of once. Chesapeake Crematory 12/28/2004 Beltsville, MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, 21. Signature of Funeral Service Licensee Strange. 7400 Georgia Ave., N.W. Wash., D.C. 20012 23a. Part. Enter the disease, or complications that cau et the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Renal Disease /Medical Due to (or as a consequence of) Examiner Atherosclerotic Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Sacral decubitus ulcer stage 4, type 2 diabetes, 1 Yes 2 No 3 Probably 4 X Unknown peen peripheral vascular disease, coronary artery disease, 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an has bilateral above knee amputations performe certificate 1 Tes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Xatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

O

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) DEC 27 2004

30. Name and address of person who completed cause

Robert H. Gerard, M.D.

1500 Forest Glen Road, Silver Spring, MD 20910 32 Registrar's Signature

or death (Item 23a) (Type, Print)

55522

December 21, 2004

		1 - For State Registrar 1. Decedent's Name (First, Middle, I	ast)	C	ertificate of	Death	2. Date of D	Reg. No.	004	4 2 5 2 l
hysicia	an	Perry Hayden Ma					Month	Day		
/Medic		4a. Facility Name (If not institution, o		·)	4b. City. Town.	or Location of Deat	Deceml		2, 2004 County of Death	0:49
xamin	er	Washington Adve		,	Takoma				Montgom	
neral			. Sex 7. A	ge (In yrs. last birthda	y) If Under 1 Year					place (State or Forei untry)
ctor		216-16-0326	1 © M 2□ F	81 Yrs.	Months Days	Hours Min.	March 2			ryland
		Usual Residence of Decedent		10c. City, Town or	il casting					10d. Inside City Limi
3	_	10a. State 10b. County								1 Yes 21
any injury or other traumatic avant, in e walks i Examinat is ust be numed at Once.	ecto	Maryland Mon 10e. Street and Number	tgomery	Silve	er Spring			10a Citia	zen of What Cou	
	ក្ន			/ ·						ariti y r
	Funeral Director	3128 Gracefield	Rd., #105			Hispanic Origin? (S	oecify Yes or N		USA 14. Race - Amer	ican Indian
	E	1 Never Married 2 Married	Armed Forces]No i	Was Decedent of I If Yes, specify Cub		to Rican, etc.)		Black, White	, etc.
	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	1943-46	1 ☐ Yes 2 🛣 No	Specify:			Specify: Whi	te
	ted	15. Decedent's		16a. De	cedent's Usual Occu ive kind of work done	pation	atria a	16b. Kir	nd of Business/I	ndustry
- 1	pie	(Specify only highest (Secondary (0-12)	College (1-4o	- life	e. DO NOT use retire	ed) ed)	rking			
	Completed	11		M∈	echanic/Pr					Own Busin
	Be (17. Father's Name (First, Middle, La	st)			18. Mother's Nar	me (First, Middle	e, Maiden :	Sumame)	
	2	Zachariah Hayd	en Matting	ly		Clara	Elaine	John	son	ALC: UK
		19a. Informant's Name/Relationship		19b. Ma	ailing Address (Street	t and Number or Ri	ural Route Numi	ber, City or	Town, State, Zi	ip Code)
		Mary B. Matting	ly/Wife		Gracefield	Rd, #105 (
		20a. Method of Disposition 1 Burial 2 □ Cremation 3	☐Removal from State	cemetery, c	sposition (Name of crematory or other pla Memorial	ace) Dece	nber 27	20c. Loc	cation - City or T	fown, State
		'4 □Donation 5 □ Other (Spe		Park			004			Maryland
DC8.		21. Signature of Funeral Service Lic	censee	7. E	22 Name and Addre	ess of Facility Collins	Funeral	l Hom	e Inc	
a		Mahlu	> Con		500 Univer				Spring	
		disease or condition	N	and 1	ai li	ing, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
ner transit	il Examiner	disease or condition resulting in death) Sequentially list conditions, and the sequentially list conditions, and the sequential list cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last	b. Jua to (5r a	is a consequence of):	ai li lio myc mary	plol hathe	l clu	LOV	P	Interval Between Onset and Death
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of F			iene 00	4 42525	
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death	
	Physici /Medio		Marguerite Eth	nel Mande	lson			December		004 10:05 a M	
	Examin		4a. Facility Name (If not institution, give s				own, or Location of Death 4c. County of Death				
			17 Holly Terrace 5. Social Security Number 6. Sex 7. Age (In yrs. last by			Cambr			Dorchester		
	Funeral Director			M 25 F 7. Age	(In yrs. last birthday) 63 Yrs.	Months Days	Hours Mir		Year) 9	Birthplace (State or Foreign Country) Maryland	
	_	}	Usual Residence of Decedent					oure i	121	raryiana	
	nylan ihow	_	10a. State 10b. County		10c. City, Town or Lo	cation				1.0d. Inside City Limits	
0	Ba-1 s	cto	MD Dorches	ster		Cambr	ridge			1 Tyes 2 No	
Ú	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Itams 23a or 28a-f show event. I'r, Medical Examinational to indiffed at	Director	10e. Street and Number 17 Holly Terrace			10f. Zip Code	21613	1	0g. Citizen of Wha USA	at Country?	
3	eath is 23	Funeral		12. Was Decedent E	ver in U.S. 13.1	Was Decedent of H		Specify Yes or No.		American Indian	
(0	r Itan	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕱 No	,		an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		White, etc.	
93	ral', o	i by	3 ☐ Widowed 4 D Divorced	If Yes, Give Year or Dates:		I□Yes 2. XXNo	Specify:		Specify:	white	
5-0	72 h	Completed	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occup kind of work done	during most of we	orking	16b. Kind of Busin	ness/Industry	
121	within ene. than "	mp	Elementary/Secondary (0-12)	College (1-4or 5+) IIT Ø. 1	nor use retired secret	•		aublic	c school	
d 2	e filed within al Hygiene. other than vent, The Ma	e Co	10 17. Father's Name (First, Middle, Last)	2		Secret		ame (First, Middle, M		SCHOOL	
Maryland 21215-0036		To B	John Henry Walke	er			Teres	sa Julia d	Jamar		
ary			19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	g Address (Street	and Number or F	Rural Route Number	City or Town, Sta	ate, Zip Code)	
Σ.	as 1 and 2 should of Health and Mer item 27 is marke r other traumatic		Julia Wood	si			race, Ca	ambridge,	MD 216	13	
Baltimore,	ges 1 t of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re	amoval from State	20b. Place of Dispo	sition (Name of natory or other plac	· 1		20c. Location - Cit		
Ë	t. Pa ntmen rtant: njury		* 4 □ Donation 5 □ Other (Specify)		Salisbury			/27/04	Salisbu		
Bal	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signaturi of Funeral Service Aicense	e		Name and Addre		Thomas Fur Cambridge			
			23a. Parti Enter the disease, or complice shock, or heart failure. List only on	cations that caused to e cause on each line	he death. Do not ent	er the mode of dyir	ng, such as cardia	ac or respiratory arre	est,	Approximate Interval Between	
	Pnysician		Immediate Cause (Final disease or condition	Ivansi	rona co	ullind	ma of	denal		Anset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	allino	S)	(vis			
		į.	Sacusaristy list conditions if any, leading to immediate	Due to (or as a	consequence of):		(
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	,							
oʻ	be executed sician and burial-transit	Еха	resulting in death) Last	Due to (or as a	consequence of):						
8760,	icate be ex physician the buria	dical		-							
9	n certifica anding ph use as t	Med	IF FEMALE:								
Вох	the death certificate be executed y the attending physician and Iched for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o	Fetal death 3	Ectopic pregnancy	1		23d. Date of Month	,	
o.	that the de ed by the a detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me or death 5L	Other (specify) _					
Q	that the standard	by Ph	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribu	ite to the cause of death?	
rds	requires that een signed b nould be deta							1 □ Y6	s 2 □ No 3[Probably 4 □Unknown	
Records,	> 0 ts	Completed						24a. Was a		re autopsy findings available	
Ä	0 5 0	Com						autops perform	ned?// dea	r to completion of cause of th? Yes 2 No	
Vital	sician: Th certificate irector, pag	Be (25. Was case referred to medical examiner?					eath (Check only on	9)		
of \	Physician: this certific ral director,	၉	1 ☐ Yes 2 Œ No H	ospital: 1 Inpatien			4 Indising	Home 5 Reside		(Specify)	
	ing After une	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injur Wor M 1 □	yat k? Yes 2 ∐No	28d. Describe ho	w injury occurred		
Division	tan feat tor: the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	y - At home, farm, str		162 5 140	28f. Location (St	reet and Number o	or Rural Route Number.	
=	al or Attand after death Director: / d in by the f	Certification:	4 Homicide determined	building, etc.	(Specify)	50t, radiory, 61100		City or Town	, State)		
	Hospita 4 hours Funara ely fille	Medical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of ter: On the basis of e and manner state	my knowledge, death	occurred at the tir restigation, in my o	ne, date and place pinion, death occ	e, and due to the ca curred at the time, da	iuse(s) and manne ate and place, and	er as stated. I due to the cause(s)	
	To the within 2. To the I complet	Me	29b. Signature and title of certifier	and mumber state		29c, Licens	e number	25	9d. Date signed (A	Mon i h, Day, Year)	
	. , , , ,		> Dund \u	MM	-	03	1887		12/27	(04	
			30. Name and address of person who con	mpleted cause of dea	ath (Item 33a) (Type	Print)	9,	MI			
			David H Smith M.		ob tintails	br Ste5	caston	MD 216	01		
	Sta Registr		DEC 2 8 200		's Signature	ale .					

			For State Registrar	State of Maryland	d / Depa <i>Cer</i>	artment of H tificate of	lealth and <i>Death</i>		giene 0 0 L	42526
	Bhysioi	an.	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day Year	3. Time of Death
	Physici /Medic		Mildred	Mayes	3				er 23, 200	
	Examin	er	4a. Facility Name (If not institution, give s Fort Washington	· ·		4b. City, Town, or Location of Death Fort Washignton 4c. County of Death Prince George*				
	Funeral	₹.	5. Social Security Number 6. Sex		ıst birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birtl		rthplace (State or Foreign Country)
	Director		578 66 8961 ¹	^M XX ^F 90	Yrs.	Months Days	Hours Min	. (Month, Day July 10	, 1914 Ma:	ryland
	and w		Usual Residence of Decedent 10a. State 10b. County				10d. Inside City Limits			
	Maryl -f sho lied a	tor	Maryland Prince	Coorgola			1 ☐ Yes 2 ☐ No			
	h the or 28e	Director	10e. Street and Number	dedige 5 Por		10g. Citizen of What C	Country?			
	23a c	raiD	10126 Griff	Drive		20	744		United	States
	er des items ner m	nue		Was Decedent Ever in U.S Armed Forces?		Vas Decedent of H f Yes, specify Cubi	lispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh	
336	ar, or	by Funeral	1 ☐ Never Married 2 ☐ Married 3 📉 💥 idowed 4 ☐ Divorced	1 ☐ Yes XX No If Yes, Give Year or Dates:	1	I ☐ Yes 2√XNo	Specify:		Specify:	White
20	72 hou	ted	15. Decedent's Educ			lent's Usual Occup		orkina	16b. Kind of Busines	s/Industry
2	vithin ne. hen "u	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	d)	in King	0 11	
15 15	filed v Hygie thert	e Co	17. Father's Name (First, Middle, Last)		nou	sewife	18. Mother's Na	me (First, Middle,	Own Ho	ome
au	lid be lental ked o ic eve	To Be	Christian Lud	wig				a Fassel	,	
Maryland 21215-0036	and Market Strong		19a. Informant's Name/Relationship (Typ	Daughter)		-			r, City or Town, State,	Zip Code)
∑ 3`	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f show it it item 27 is marked other than "natural", or items 23a or 28a-f show or other treumetic event, it is Madical Examiner must be notified at		Charlotte Joan Hu				Drive, F		Ington, MD	20744
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Re	Ce	metery, cren	sition (Name of natory or other place atory De	ce)	Date	Clinton,	
틆	nit. Pa artmer ortent injury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License						ral Home,	
B	permit. Departn Importe eny inju		Vat DATO	h 10015.						on, MD20735
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death e cause on each line.	. Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	lucs	epsis)				Onset and Death
H	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):					U
	* _	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):					
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
8760,	cate be executed bhysicien and the burial-transit	i Ex	resulting in death) Last	Due to (or as a consequ	ence of):					
387		edicai	d							
9 xc	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnar		_			23d. Date of de	alivery
Division of Vital Records, P.O. Box	death	by Physician/M	in the past 12 months? 1 □ Yes 2 ② No	1 Live birth 2 ☐ Fetal 4 Pregnant at time of de 9 Unknown		Ectopic pregnancy Other (specify)	/ - 		Month	Day Year
<u>Ч</u>	that the de led by the detached	Phys	9 Unknown		Nime in the second		on in Book	OZO Did to	haasa uus saatsihuuta	to the course of death?
ds,	8 5 8		Part II. Other significant conditions con	tributing to death but not resu	iting in the ur	nderiying cause giv	en in Parti.		bacco use contribute es 2 KNo 3 ☐ F	Probably 4 []Unknown
COL	w require been sig should t	Completed						24a. Was a	`	utopsy findings available
Be	The lav ate has page 2	ошо						autops perfor 1 Yes	sy prior to med? death?	completion of cause of
<u>ta</u>		Bec	25. Was case referred to medical examiner?				26. Place of De	ath (Check only or		5 2 2 1 1 1 1
<u>></u>	d is	P.	1 ☐ Yes 2 No		R/Outpatien		4 🗆 Nursing i	T-	ence 6 Other (Sp	ecify)
uc C	ding F	ion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2 ⊡No	28d. Describe h	ow injury occurred	
/ISI	or Attending after death. Director: After in by the funer	fica	3 Suicide 6 Could not be	28e. Place of Injury - At hor					treet and Number or F	Rural Route Number,
á	ospitel or / hours after unerel Dire ly filled in b	Certification:	4 Homicide	building, etc. (Specify,				City or Tow	n, State)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examin	ician: To the best of my know er: On the basis of examinati	vledge, death on and/or inv	occurred at the tir	me, date and plac pinion, death occ	e, and due to the curred at the time, o	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	o the ithin 2 o the omplei	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	2	29d. Date signed (Mor	ith, Day, Year)
	⊢ s ⊢ ō			m Boremo		DY	6285	>	12-23-04.	
			30. Name and address of person who cor							
N	168		Paul Bone, M.D.	10905 Ft. Wa	shingt	on Road	SUite 20	6 Ft. Was	shington, I	MD
	Sta Registr	- 3	31. Date filed (Month, Pay Year) B C 2 8 2	32. Registrar's Signate	J.	book				

MOORE,

		1	For State Registrar	State of Mary	/land / Dep	artmei		ealth and	Mental Hy		004	42528
			. Decedent's Name (First, Middle, Last)						2. Date of D			3. Time of Death
	sician edical		CHARLES	WAYNE	MINN	IICK			Decemb	er 25.	2004	12:45P M
	miner		a. Facility Name (If not institution, give s	treet and number)			Town, or	Location of Dea			ounty of Death	
		H	Kline Hospice	House		Me	ount	Airy		Fı	rederio	rk
Fune	eral	5.	Social Security Number 6. Sex	7. Age (II	yrs. last birthday,		r 1 Year	If Under 24 Hr				pplace (State or Foreign intry)
Direc										2 Mar	vland	
ъ.		_	sual Residence of Decedent									
rylar	9		Oa. State 10b. County		c. City, Town or L							10d. Inside City Limits
M A	oto	1	Maryland Freder:	ick	Bruns	wick						1 X Yes 2 ☐ No
th th	i e	10	0e. Street and Number			10f. Zi	p Code			10g. Citizer	n of What Cou	untry?
th wil	by Funeral Director		15 East C. Stree	et			2171	6		Unite	ed Sta	ites
dea	le l	1	1. Marital Status	Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Dece	dent of His	panic Origin? (Specify Yes or Norto Rican, etc.)	o- 14.	Race - Amer	
6 after	E		1 XNever Married 2 Married	1 ☐ Yes 2 🛣 No					ito nican, etc.)		Black, White	
Ours ral',	l o		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 🗌 Yes	2X) 140	Specify:		Sp	pecify: W	hite
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/la	<u>0</u>		Robert D.	Minnick	ς			Hele	n	Fore	eback	
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked othat then "natural", or Itams 23a or 28e-f show any injury or whee trainmains as on the then	5	20	Da. Method of Disposition		20b. Place of Disponentery, cre	osition (Na	me of		Date		tion - City or T	own, State
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(6))	3	0. Name and address of person who con	mpleted cause of death	(Item 23a) (Type		J Car	V) !		,	0/-	
9			Dr. Pamela Heath	110 Baughm		•	lerick	. Marv	land 21	702		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 001 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Harry Robert McArdle 23, 6:00 p Dec. 2004 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 1177 Ramblewood Drive Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1 X M 2 □ F 80 192-14-0011 Yrs 1924 Mar. 3, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Anne Arundel Annapolis 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1177 Ramblewood Drive 21401 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No WW] If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 22 Married WWII 1 ☐ Yes 2 X No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Project Engineering Manager Gould 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry McArdle Lillian Moxen ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Louise McArdle/Wife 1177 Ramblewood Drive, Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dec. 27, 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, MD Metro Crematory 4 □ Donation 5 □ Other (Specify) 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchic Lwy, Severna Park, MD omes, 21146 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ONA RS ears disease or condition resulting in death) Due to (or as a consequence of): ronav Sequentially list our ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 3□ DQA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 96 30. Name and address figerson who completed cause of death (Item 23a) (Type, Print) 1/6 Detense 31. Date filed (Month, Day, Year) 32. Paistrar's Signature

Registrar

State

within 24 hours after common To the Funeral Director: /

Physician

/Medical Examiner

Funeral Director

filed within 72 hours after death with the Maryland Show 7 is marked other than "natural", or Items 23a or 28e-f shov traumatic event, the Medical Examination is the notified at permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If item 27 is marked other than 'a way injury or other traumatic event, the Magnets.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed as the burial-transit the attending physician Division of Vital Records, P.O. Box 68760 esn į detached signed by peen page 2 certificate To the Hospital or Attending Physician:

Completed Be 2

Certification:

Medical

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	_		Registrar				Cei	tificate o	f Death			og. 110.	004	42530
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	uneral irector		5. Social Security Nu 378-09-1	893	Sex 1 □ M 2 🔀 F	7. Age (In yrs. 92	. last birthday) Yrs.	If Under 1 Yea Months Day		Min.	B. Date of Birth (Month, Day Mar. 31	Year) , 191	9. Birthi Cou	place (State or Foreign ntry) MT
and	M H	-		10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
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DHMH 17 Rev 1/2001

B.K.S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien® 0.01

		1 State Registrar	otato o marytan	Cei	rtificate of	Death	i wontan i iy	Reg. No.	U4	42531	
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/Med	ical	Randolph M 4a. Facility Name (If not institution, give			4h City Town	or Location of De		23, 200	04 ^{ear}	0624 A M	
Exam	ner	PRINCE GEORGES HO						,		ORGES	
Funera Director		5. Social Security Number 6. Se 577–64–6158	7. Age (<i>In yr</i> s. 36	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi		rth ay, Year)	9. Birthp	place (State or Foreign oftry) sh., DC	
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r 28a	Director	10e. Street and Number			10f. Zip Code	Vashingto	on	10g. Citizen of What Country?			
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To th within To th compl	Me	29b. Signature and title of certifier	-		29c. Licens	se number C.M.E		29d. Date signed DEC •	(Month, 1 23, 2		
(10)		30. Name and address of person who c	ompleted cause of death (Item	1 23a) (Type, 1	Print)						

Registrar DHMH 17 Rev 1/2001

State

AMA
31. Date filed (Month, Day, Year)

DEC 2 9 2004

RUGIO, MIO 111 PENN STREET, BALTIMORE, MARYLAND 21201

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	Physic /Medi		Dwayne Allen						er 22, 200		
7	Examir	er	4a. Facility Name (If not institution, g 2408 Virginia Av	ive street and number) 7C •		Landover	r Location of Death	1	4c. County of Prince		
	Funeral			Sex 7. Age (In yrs. la	ast birthday)		If Under 24 Hrs. Hours Min.	8. Date of Bir		Birthplace (State or Foreign Country)	
	Director		212-27-5997 Usual Residence of Decedent	¹\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Yrs.	Months Days	Hours Min.	Dec. 6,	1913	Wash., DC	
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits	
	e Man	Director	Maryland Princ	e George's		Seat Ple	asant			1X Yes 2 □ No	
	deeth with the Maryland ms 23a or 28a-f show	Dire	10e. Street and Number	- h Ch		10f, Zip Code	207/2		10g. Citizen of Wh		
	ns 23a	Funeral	510 - 71	12. Was Decedent Ever in U.S	S. 13, V	Was Decedent of H	20743 lispanic Origin? (Si	pecify Yes or No		ed States American Indian,	
Maryland 21215-0036	ours efter el', or Ite Examina	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	Specify:	o Rican, etc.)	Black, Specify:	White, etc. Black	
5-0	72 hours "naturel", adical Exe	letec	15. Decedent's (Specify only highest of	Education grade completed)	16a. Deced	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of wor	king	16b. Kind of Busin	ness/Industry	
12	be filed within 72 ho Ital Hygiene. Id other than "natur event, the Medical	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	111 0 . 1		" & Mechar		Pri	ivate	
b	e filed al Hygie other vent, II	Be C	17. Father's Name (First, Middle, La	st)					, Maiden Sumame)	- Vacc	
ylai	2 should be f n and Mental H is marked of reumatic eve	To E		L. McClaine					lean Turne		
Mar	s 1 and 2 should f Health and Men fem 27 is marks other treumatic	8 4	19a. Informant's Name/Relationship						er, City or Town, St		
	of Health of Health of Health of Item 27 I		Claradean McCla 20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of		Date Plea	20c. Location · Ci	ty or Town, State	
E S	Page nent o int: If		1 ∰Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spec	i Removal from State		natory or other place 1n Cemete		29/2004	Brenty	wood, MD	
Baltimore,	permit. Pages Department of h Importent: If its any injury or of once.		21. Signature of Funeral Service Lic	4	22	. Name and Addres			Funeral H	Iome	
	<u>405</u> 8 9		23a Part 1 Fator the disease or se	Lewall III	- Do not ont				Wash., I	OC 20019 Approximate	
	Physician /Medical Examiner	<u>.</u>	23a. Part1. Enter the disease, or co shock or heart failure. List on Immediate cause (Final disease or condition resulting in death) Sequentially list conditions,	b. Due to for as a consecu	wo to		m	_		Interval Between Onset and Death	
68760,	certificate be executed iding physician and ise as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ							
P.O. Box 6	death certif e attending d for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 □	Ectopic pregnancy Other (specify)			23d. Date o		
	requires that the een signed by thi rould be detache	by P	Part II. Other significant conditions	contributing to death but not result	lting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use contribu	ute to the cause of death?	
ord	w require been si	eted						10'	Yes 2.27No 3[Probably 4 Unknown	
al Records,	The lavate has	Completed						24a. Was autor perfo 15 Yes	rmed? dea	re autopsy findings available in to completion of cause of th? Yes 2 No	
Vital		To Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 E	ER/Outpatien	t 3 DOA Othe	er: 4 Nursing H	th <i>(Check only c</i> ome 5 ☐ Resid		(Specify) (scene)	
10			27. Manner of Death 1 Natural 5 Pending		28b. Time of Injury	28c. Injury Work	y at	28d. Describe I	now injury occurred		
Siol	Attending r death. sctor: After by the fune	catle	2 Accident investigate 3 Suicide 6 Could not	on 12/22/04 -	7:58 1	D M 1□	Yes 2 XNo	SUBTEC			
Division of	To the Hospital or Attending thin 24 hours effer death To the Funerel Director: completely filled in by the	Certification;	4. Homicide determine	building, etc. (Specify))	street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 208 V 1 R6 / N 1 A N E , LANDO SER , M					
	24 ho 24 ho B Funk etely fi	Medical	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex-	Physician: To the best of my know aminer: On the basis of examinati and manner stated.	viedge, death ion and/or inv	n occurred at the time vestigation, in my op-	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and manne date and place, and	er as stated. I due to the cause(s)	
	To the within To the compl	Me	29b. Signature and title of certifier	4		O.C.M	LE.	I	29d. Date signed (A December 2	23, 2004	
4	2(6)					Print) 111 Pe	nn Stree	t, Balti	more, Mai	cyland 21201	
	Sta Registi		DEC 2 9 200	Registrar's Signatu	do do	W					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42534 For State Registrat Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year Physician 00 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number Town, or Location of Death **Examiner** 6. Sex Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Davs Hours 1 M 2 XF none manyland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Maryland aur 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No If Yes, Give nited Items 23a 20 filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 5 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced Year or Dates: natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) STAK -n tant item 27 is marked othe other traumatic avent, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental I ant: If item 27 is marked o uckhurs Len ပ္ rank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3001 S. Hanover Street Baltimore, MD 21225 Harbor Hospital Center 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ♣ Other (Specify) in State Department of Important: If any injury or once. ^¹ 4 □ Donation 21. Signal to of Funeral Servi State and Address of Facility and 655 W. Baltimore Street ctor 21201 Baltimore, MD plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part . Enter the disease shock, or heart failure. I Immediate Cause (Final extreme Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Year 4☐Pregnant at time of death 5 Other (specify) P.O. I ed by the a 9 Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 ☐ Yes 22 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No certificate 25 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: Inpatient 3 DOA ဥ 1 ☐ Yes 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral Date of Injury (Month, Day Year, 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Natural 5 Pending investigation 1 🗌 Yes M 2 🗌 No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Chack on one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number December 12, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN

11

			State of Maryland / Department	artment of Health and I rtificate of Death	Mental Hygiene	004 42535			
	Dharini		Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death			
	Physici /Medio		Larry Wayne Nave		December 29,				
	Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	unty of Death				
	Funeral		15735 Fenton Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Williamsport If Under 1 Year If Under 24 Hrs.		9. Birthplace (State or Foreign Country)			
	Director		220-58-3700 ¹ ⋈ ^M ² □ F 52 Yrs.	Months Days Hours Min.	March 17,1952				
	pur 🛦 ::		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Letter 1	ocation		10d. Inside City Limits			
	Aaryle f sho	ō				1 ⊠Yes 2 □ No			
	the h	Director	Maryland Washington Williams	10f. Zip Code	10g. Citizen	of What Country?			
	h with	a D	15735 Fenton Avenue	21795	USA				
	ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	Race - American Indian, Black, White, etc.			
36	72 hours after death with the Maryland naturel', or Items 23a or 28e-1 show dies. Exercinet from the motified at	by Fu	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	Spe	ecify:			
5-0036	hour sture!		15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind o	White of Business/Industry			
215	hin 72	plet	(Specify only highest grade completed) (Give life.	kind of work done during most of wor DO NOT use retired)	_				
2121	ed wit	Completed	11 0 Labor			truction			
and	be fill tal Hy ad oth	Be	17. Father's Name (First, Middle, Last)		ne <i>(First, Middle, Maiden Sur</i> ne Ellen Metz	name)			
Maryland	hould d Mer marke matic	၉	Alex Bradley Nave Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Ru		wn, State, Zip Code)			
Ma	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23a or 28e-f show other treumatic event, if a Michel Exaction or item retilined at			Fenton Ave. Wil					
Je,	of Hear item		20a. Method of Disposition 20b. Place of Disposition cametery, cre-	osition (Name of matory or other place)	Date 20c. Locati	on - City or Town, State			
Ē	Page nent ent: If ury or		1 Libural 2 Cremation 3 Linemoval from State	g Crematory 12-30	0-04 Smiths	burg, Maryland			
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or items any injury or other freumatic event, If a Maries Examiner is once.		21 Signature #Funeral Service Liebnseal 2	2. Name and Address of Facility Sporne Funeral Hol III amsport, Mary	rend 21795 S.	Conococheague St			
			23a. P. T. Enter the disease, or complications that caused the death. Do not en strick, or heart failure. List only one cause on each line.			Approximate Interval Between			
	Physician		Immediate Cause (Final	erotic Cardion	(M): -	Onset and Death			
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	-	Co				
	Lxaiiiiiei	_	Sequentially list conditions, if any leading to immediate b. Due to total a consequence of):	sion					
	ted nsit	Examiner	Cause (Disease or injury	Moll: Lie					
<u>_</u>	execu n and ial-tra	Ехаг	that initiated events resulting in death) Last Due to (or as a consequence of):	Leu HS					
8760,	eath certificate be executed attending physician and for use as the burial-transit	dical	d						
9	artifica ing ph e as tl	Med	IF FEMALE:						
Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)	23d.	Date of delivery Month Day Year			
Ö	y the c	ıysıc	1 Yes 2 No 9 Unknown						
σ.	uires that signed b d be deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco use o	contribute to the cause of death?			
rds	w requires been sig should b	ed b			1 ☐ Yes 2 ☐ N	o 3 ☐ Probably 4 Munknown			
ဝ၁	law requ as been 2 shoulk	plet			autopsy	4b. Were autopsy findings available prior to completion of cause of			
E E	The cate h page	Completed			performed? 1 ☐ Yes 2 No	death? 1 ☐ Yes 2 ☐ No			
Vita	24a. Was an autopsy inding autopsy i								
of Vital Records,	Physic this cral dir	2	1 Tes 2 No 1 Inpatient 2 En/Outpatier	f 28c. Injury at	lome 5 Residence 6 28d. Describe how injury of				
Division	ding th. : After	Certification;	27. Manner of Death 17 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work? M 1 ☐ Yes 2 ☐ No					
Visi	Atter	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and No City or Town, State)	umber or Rural Route Number,			
	rs after or el Dir	Cert	Pallang, St. (Speeny)		,				
	Hosp 24 hou Fune tely fil	Medical	29a. Certifier (Check only one) Wedical Examiner: On the basis of examination and/or in and manner stated.						
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Mec	one) and manner stated. 29b. Signature and Hitte of Sertifier /	29c. License number	29d. Date si	gned (Month, Day, Year)			
	r ≤ r ŏ		A THE AL DO FACT	1440884	29 De	centrer 2004			
2	.,		30. Name and addr is of person who completed cause of death from 23a) (Type	Print) WASHING TO	29 De N county Hs Sn, MD 21	pital			
9	H-1		Thomas J. Gilbert, AT, U.S. t.	ACT Hagerston	sn, m5 21	740			
	Sta		31. Date filed (Month Day, Year) 32. Registrar's Signature	nouted	٤				
	Registi	ar	There is the	ANTE					

			1 - For State Registrar	State of Mary		artment of H		Mental Hy	giene Reg. No 200	4 42536	
	Physici	an	Decedent's Name (First, Middle, Last)					Month	Date of Death Month Day Year 3. Time of Deat		
	/Media	cal		M. Nagel		Ab Car Tarra	Laurence of Da	Dec.	23, 2002		
1	Examir	ier	4a. Facility Name (If not institution, give street and number) William Hill Manor			4b. City, Town, or Location of Death Easton			4c. County of Death Talbot		
Н	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)								
	Director		214-10-42/2]M 2 k]F	86 Yrs.	Months Days	Hours M	Apr. 23	${}^{\text{rth}}_{ay, Year} = 0.0$	elaware	
	Maryland	Funeral Director	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits	
			MD Caroli	ne		Federa1	sburg			1 ☐ Yes 2K No	
Maryland 21215-0036	h the		10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	10g. Citizen of What Country?	
	Pages 1 and 2 should be tiled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other then "netural", or items 23e or 28e-1 show iry or other treumatic event, the Medical Examiner must be notified at	alD	3901 Old Denton Road						United S	United States	
		Completed by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or Ne erto Rican, etc.)	o- 14. Race - A Black, V Specify:	American Indian, Vhite, etc. White	
			15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Dece	dent's Usual Occupa	ation Juring most of v	vorkina	16b. Kind of Busine	ess/Industry	
			Elementary/Secondary (0-12)	College (1-4or 5+)	_	kind of work done of DO NOT use retired)	ionang	Law Off	ices	
			17. Father's Name (First, Middle, Last)		Sec	retary	18 Mother's N	lame (First Middle	, Maiden Sumame)		
		To Be	Isaac Noble				Susi				
ary			19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailin	ng Address (Street a			er, City or Town, Sta	te, Zip Code)	
altimore, Ma			Sue N. Banning/				e Ave.	, Feder	alsburg,	MD 21632	
			20a. Method of Disposition 1 屎 Burial 2 □ Cremation 3 □ R	emoval from State		natory or other place		Date	20c. Location - City		
	Department Department Mportant: any injury once.		' 4 ☐ Donation 5 ☐ Other (Specify)			Cemete	- 1			sburg, MD	
Bal	permit. Poppartm Importal any injui		21. Signal of Feneral Service License	m. Coa	ee 21	U N. Ha	III OL.	, reuel	arspurg,	Home, P.A. MD 21632	
	Physician /Medical	Completed by Physician/Medical Examiner	23a. Farti. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the te cause on each line. Due to (or as a co	estive insequence of):			ene or respiratory a		Approximate Interval Between Onset and Death	
Division of Vital Records, P.O. Box 68760,	The law requires that the death certificate be executed to the has been signed by the attending physician and age 2 should be detached for use as the burial-transit of the contract of the co		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or usa con	nsequence of):	e car	droni	pathy		20 YSB	
			that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):						
				l							
			FEMALE: b. Was decedent pregnant in the past 12 months? 1						23d. Date of delivery Month Day Year		
	that ned by deta		Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did 1	23e. Did tobacco use contribute to the cause of death?		
	The law requires sate has been signings 2 should be		Kenal insufficiency					_ 1 🗆	Yes 2 0 3] Probably 4 □Unknown	
			Myclo dyspearth synds						s an 24b. Were autopsy findings available prior to completion of cause of death?		
		e Cc	25. Was case referred to medical	26 Place of Dec			1 Yes	1 Yes 2 No 1 Yes 2 No			
	or Attending Physiter death. Director: Atter this in by the funeral directors.	To B	examiner? 1 Tes 2 No	t 3 DOA Othe	Other: 4 Viursing Home 5 Residence 6 Other (Specify)						
			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injury Work			how injury occurred	. ,,	
		Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆 Y	res 2 □ No	00(1			
								wn, State)	r Rural Route Number,		
	To the Hospitel within 24 hours a To the Funerel i completely tilled		29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
)	with To		29b. Signature and title of certifiery			D35284			29d. Date signed (<i>Month, Day, Year</i>) 12		
			30. Na and address o person who completed cause of death (Item 23a) (Type, Print) AMBREA ALLEN MD 219 S. WashingAm St. Easton, Md. 21601								
	Sta Registr	1	31. Date filed (Month, Day, Year)	32. Registrar's S	-	Ale an			·		
DH	MH 17 Rev 1/2	-0	DEC 2 9 2	004	1 150	G-13-14 1			1 1 1		

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Joseph Anthony Orlando Dec. 2004 7:20 AM 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12303 Sherwood Frederick Mt. Forest Drive Airy If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1⊠M 2□F 50 218-66-3427 July 13, 1954 Director Washington, DC Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Frederick Mount Airy 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 12303 Sherwood Forest Dr. 21771 or Items 23a United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ջ Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Building/Construction Building Engineer permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic avera-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Ρ. 0rlando Anne Dusterhoff ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12303 Sherwood Forest Dr./ Mt. Airy, MD 21771 Harrison / mother Anne 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick Crematory Dec. 26,2004 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home, P.A. 8 E. Ridgeville Blvd. / Mt. Airy, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Henotic /Medical **Examiner** Henstic Due to (or sa consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit E50 pha Due to (or as a consoluence of) attending physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown signed by the feet of the second Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 20 Other: 1 🗌 Yes r 1 Inpatient 2 ER/Outpatient 3 DOA Νa this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Man er of Death 28b. Time of Certification: After 1 Natural
2 Accident Injury 5 Pendina al or Attendin s after death. Il Director: Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital within 24 hours a To the Funeral I **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 014626 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zausch 31. Date filed (Monting) (Yes) 32. Registrar's Signature 2004 7 State Registrar

			For Stata Registrar		State of	f Marylar		artment of H		nd Mental H	ygiene 0	04 4	2538
	Physici /Medic		1. Decedent's Name (First, Tuanifa	Middle, Last,		rice				2. Date of Decem	Day	Yeer	ime of Death
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	Funeral Director		5. Social Security Number 217–60–7808 Usual Residence of Decede		х М 2 5 F	7. Age (In yrs. 53	Yrs.	Months Days		Min. (Month, L	Day, Year) 14 1951	Washing	State or Foreign
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21215-0036	d within 72 hours a giene, ir than "natural", o	Completed	(Specify only Elementary/Secondary (0	Ť		-4or 5+)	(Give	dent's Usual Occupi kind of work done of DO NOT use retired	durina most o	f working	16b. Kind of E	Business/Industry	
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Maryland	ges 1 and 2 should be file. t of Health and Mental Hyg If item 27 le markad otha or other traumatic event,	To Be	John Willia 19a. Informant's Name/Rei	m Davi			105 Mailt	ng Address (Street	Lac	ie Blac	k		
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	ss 1 and 2 of Health itam 27		20a. Method of Disposition			20b. I	Place of Dispo	osition (Name of matory or other place	1	Date		- City or Town, St	
E O	Pages net of nrt: If it		1 ☑ Burial 2 ☐ Crema 1 ☐ Donation 5 ☐ Ott			State		Cemetery	1	/30/04	Landove	r,Maryla	and
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Se	rvice Licens	98		2:	2. Name and Addres	ss of Facility	J. B. Jei	nkins Fu	neral Ho	me
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	/Medic Examin		4a. Facility Name (If not institution,		·	4b. City, Town,	or Location of Death		40	. County of Death	
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Maryland	od o	Be	Frederick W.	Palmer, Sr	•		Anna	Augus		,	
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	To the within 2 To the complet	Me	29b. Signature and title of certifier	1/2		29c. Licer	se number		29d. Da	ate signed (Month	, Day, Year)
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Registrar

State

31. Date filed (Month, Day, Year) DEC 27 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SAIMA KHAWAJA, M.D. 11119 ROCKVILLE PIKE, SUITE #100, ROCKVILLE, MD. 32. Registrar's Signature

20852

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepe Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Physician Dec 23, Anthony Piacente 2004 6:40 P /Medical 4b. City. Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street end number) Examiner 7203 Westchester Drive Camp Springs Prince George's If Under 24 Hrs. Birthplace (State or Foreign Country) Italy If Under 1 Year 8. Date of Birth (Month, Day, Year) March 12, 5. Social Security Number 7. Age (In yrs. last birthday) Deys XX M 2□ F Yrs. 75 1929 135 22 9610 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10e. State 1 ☐ Yes 2 ☐ No Directo Maryland Prince George's Camp Springs, 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20748 7203 Westchester Drive United States Funerai 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status N⊡Yes 2 No HYes, Give 1 ☐ Never Married XX Married Korean 1 Yes 25 No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) QC Inspector Delta Electronics 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Vito Piacente Josephine Strongoli 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 7203 Westchester Drive, Camp Springs, Md 20748 Rose Piacente (Wife) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2XXCremation 3 ☐ Removal from State Dec 28, 2004 Lee Crematory Clinton, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Seprice License ma0153 Alexandria Ferry Rd, Clinton, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Campl as e consequence of): Physician/Medical Exami Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 □ Unknown à 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Wes case referred to medical 26. Place of Death (Check only one) Be Sesidence 6 □Other (Specify) Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Avatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

attending physicien end for use es the buriel-transit or Attending Physician: The law requires thet the death certificate be axecuted certificate death. Director within 24 hours a To the Funeral D

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylend nent of Haalth and Mental Hygiene.

Int: If item 27 is marked other than "naturel", or items 23e or 28e-f show ury or other treumetic event, the Medical Exeminer must be notified at

Dapartment o important: If any injury or

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, ed by the a has been signed ge 2 should be de page Aftar this certifical funeral diractor, i filled in by

mP 204 State Registrar

4 Homicide

29a. Certifier (Check only one)

29b. Signature and

32. Registrer's Signatur 8 2004

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29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner states. 29d. Date signed (Month, Dey Year)

30. Neme end address of

			1 - For State Registrar	State of	Marylan		artment of H tificate of I			F	Reg. No:	004	425	41
	Physici	20	1. Decedent's Name (First, Middle,	, Last)						2. Date of Dea Month	Day	Year	3. Time of	
	/Medic	al	Annunziata D'Amo							December		2004	5:15	Дм
	Examin	er	4a. Facility Name (If not institution,				4b. City, Town, or		of Death			County of Death		
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			Usual Residence of Decedent							Haren .				
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and	be fi	Be	17. Father's Name (First, Middle, L	_ast/								oumanie)		
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Baltimore,	permit. Pages i Department of H Important: If ite any injury or ot		21. Signature of Fun rayS-nce/L		ROB		. Name and Addres						11011	
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			23a. Part. Enter the disease, or shock, or heart failure. List of	complications that ca	aused the deatl	h. Do not ent	er the mode of dyin	g, such as	s cardiac o	r respiratory ar	rrest,		Approximat Interval Bet	tween
	Physician		Immediate Cause (Final disease or condition	0	JOTATOR	y FAI	JAN						Onset and	Death
	/Medical		resulting in death)	Due to (or as a conseq									
П	Examiner		Sequentially list conditions,	b. Pulm	MANOUND	ENBOI	-15m							
	sit od	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consteq	uence of):								
	ecute and I-tran	хап	that initiated events resulting in death) Last	c. Die to (or as a conseq	LHROME	102R							
8760,	ate be executed hysician and the burial-transit													
687	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physiclan/Medical		d										
Box (leath certifica attending ph	JM€	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out							2	3d. Date of deliv	/ery	
B	death a atte	clai	in the past 12 months?	4☐Pregna	irth 2□Feta ant at time of d]Ectopic pregnancy] Other <i>(specify)</i>					Month	Day '	Year
0	that the de ed by the detached	hys	9 ☐ Unknown	9□ Unkno	own									
ď,	res tha signed I be det	by P	Part II. Other significant conditio		ath but not res	ulting in the u	nderlying cause give	en in Part	1.	23e. Did to	obacco us	se contribute to	~	
ırd	w require been sig should b	ed	RIGHT ATRIAL	THROMBUS						1 🗆 \	Yes 2]No 3∏Pro	bably 4-01	Unknown \
Records,	as be	pie								24a. Was autop	osy		opsy findings ompletion of c	available cause of
H	The late has page	Completed								perfo 1 ☐ Yes	rmed?	death?	2 🗆 No	
Vital	Physician: The faw this certificate has b ral director, page 2 s	Be	25. Was case referred to medical examiner?				044		e of Death	(Check only o	опе)			
of	Physic this c	2	1 ☐ Yes 2 No	Hospital: 1 ☐ II		ER/Outpatier 28b. Time o		4. N		ne 5 🗌 Resid		Other (Speci	ify)	
no	ding f	ion	27. Manner of Death 1 □ Natural 5 □ Pending	g (Monti	h, Day Year)	Injury	Wor	k? Yes 2.⊡	100	od. Describe i	IOW BIJULY	occurred		
Division	Attending in death. Sector: After by the fune	licat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could in	not be and Bloom	of Injury - At he	ome, farm, sti	eet, factory, office			28f. Location (S	Street and	i Number or Rui	ral Route Num	nber,
Ρ	after Direction	Certification:	4 Homicide determi	buildir	ng, etc. (Specif	y)	201, 120101, 7, 011100			City or Tov	wn, State)			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page			g Physician: To the										
	n 24 h	edicai	(Check only 2 Medical I	Examiner: On the ba and mann	asis of examina ner stated.	ition and/or in	vestigation, in my o	pinion, dea	ath occurre	ed at the time,	date and	place, and due	to the cause(s	\$)
	To the To the Comp	×	29b. Signature and title of certifier	V			29c. Licens					signed (Month		
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	(0		30. Name and address of person	_		n 23a) (Type,	Print)	2	< , ,	242 3	10.1			
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	Physici	an	1. Decedent's Name Richard							2. Date	of Death ember	Day 6, 2004	3. Time of Death 8:03p M
	/Medic Examin		4a. Facility Name (I	If not institution, g	ive street and numb	er)		4b. City, Town,	or Location of			4c. County of Death	
					Terrace			Oxon H		4 Hrs. 10 Date		Prince Geo	
В	Funeral Director		5. Social Security N 2 2 4 - 6 8 - 0		Sex 1 M 2 ☐ F	Age (In yrs. la 54	ast birthday) Yrs.	Months Days			of Birth yb, Pay, Ya		place (State or Foreign htry) Dama
	pu *		Usual Residence of	Decedent		10c. City	. Town or Lo	cation					0d. Inside City Limits
	Maryla f sho	ŗ	MD	,	Georges	1	n Hi						1 XYes 2 No
	death with the Maryland ims 23a or 28a-1 show	Funeral Director	10e. Street and Nu 5407 Li		on Terra	ice #3	102	10f. Zip Code 207	45		10g. US	Citizen of What Cou	ntry?
	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "naturel", or Itams 23a or 28a-1 show event. Its Madical Examiliae meat be multied at	by Funer	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied 2□ Married	12. Was Decede Armed Force 1 Tyes 3 If Yes, Give Year or Date	es? CXNo		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 X No	ban, Mexican,	n? (Specify Yes Puerto Rican, e	or No- tc.)	14. Race - Americ Black, White, Specify: Bla	etc.
2-00	72 hour naturel			15. Decedent's	Education		(Give	dent's Usual Occi	during most of	of working	16b	. Kind of Business/In	dustry
121	within end then "I	Completed	Elementary/Seco		College (1-4	or 5+)	life.	DO NOT use retir	ed)		nt Br	coadcast	ing Co.
Maryland 21215-0036	id be filed ental Hygi kad other c event.	0	17. Father's Name Emmit Pr		st)					s Name (First, I		len Surname)	
Mary	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then enty injury or other traumatic event. Item 2006.		19a. Informant's N			į.	1	-				ty or Town, State, Zip A 22026	Code)
Baltimore,	es 1 ar of Hea if item or othe		20a. Method of Dis	•	☐Removal from St	CE	lace of Dispo emetery, crea	esition (Name of matory or other pl	ace)	Date	20c.	. Location - City or To	own, State
ij	it. Pag rtment rtent:	1		5 ☐ Other (Spec	city)			Cemeter	-	/3/200		exandria al Home	a, VA
Ва	Departiment of the control of the co		nela	0.4	une of							dria,VA	22314
			shock, or hea	art failure. List on	mplications that cau ly one cause on eac	h line							Approximate Interval Between Onset and Death
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60,	be executed ician and burial-transit		that initiated event resulting in death)	S 🔳	c. Due to (or	as a consequ	uence of):						
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О. Вох	requires that the death certificate be execu een signed by the attending physician and hould be detached for use as the burial-trai	Physician/M	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	? months? □ No		n 2 ∏Fetal It at time of de	death 3[Ectopic pregnan Other (specify)	су			23d. Date of delive Month	ery Day Year
۵	res that igned b be deta	by Pł	Part II. Other signi	ficant conditions	contributing to dea	th but not resu	alting in the u	nderlying cause g	iven in Part I.	23e		o use contribute to the	
ord	w require been si should t	eted								240	ı∟ Yes		pably 4 Ninknown
Vital Records,	The lay ate has page 2	Completed								_	autopsy performed Yes 2	prior to co death? No 1 Yes	psy findings available mpletion of cause of 2 No
Vita	Physician: The this certificate ral director, pag	o Be	25. Was case refe examiner? 1 X Yes 2		Hospital:	ationt 2 1	ER/Outpatier	nt 3 DOA		of Death (Check		% Other (Specif	At. Scene
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Division	Attending r death. sctor: After by the fune	icat	2 Accident	investigat 6 ☐ Could not	be and Blace of	Injury - At ho	me. farm. st	M 1 (]Yes 2 □N		ation (Street	and Number or Rura	il Route Number,
Ŭ, i	s effer bl Dire	Certification;	4 🗌 Homicide	determine	building	, etc. (Specify	')			City	or Town, St	ate)	
	To the Hospitel or Attending I within 24 hours effer death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier (Check only one)	2 Medical Ex	Physician: To the b aminer: On the bas and manne	is of examinat	wledge, deat tion and/or in	vestigation, in my	opinion, death	place, and due occurred at the	time, date	e(s) and manner as s and place, and due to	o the cause(s)
	Within Com	Σ	29b. Signature and		ulal.	A	er"		OCME			pate signed (Month, cember 28,	
R	-4)		30. Name and add	ress of person wh	o completed cause	of death (Item			Street.	Baltim	ore, N	Maryland 2	1201
	Sta		31. Date filed (Mor		32. Reg	pistrar's Signat						-	
	Regist	ar	UE	6 4 3 200	LOOK	J 76	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 00 1 42543 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Rippeon Austin 8:50 A.M Delmar December 23, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Kline Hospice House Airy Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**⊠**M 2□F Months 11, 216-30-3231 72 Dec. 1932 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County If Item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, it a Modical Examinar must be notified at 1 ☐ Yes 2 XNo Director Thurmont Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21788 11629 A Baugher Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1

Yes 2

No 14. Race - American Indian, Black. White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Korea White 1 ☐ Yes 2 ▼ No Specify: δ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatts. Elementary/Secondary (0-12) College (1-4or 5+) Public Education Principal 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be H. Alma Austin Rippeon Beard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11629 A Baugher Road Vicki Rippeon/Wife Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick, MD ` 4 □Donation Frederick Crematory 12/27/04 21. Signature of Funeral Service Licen 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mundema disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 Live birth 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has funeral director, page 2 autopsy performed 2□ No 2 D NO 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural Injury 5 Pending 1 Yes 2 No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 91657; Prederuly, md 21201 Tanzis 31. Date filed (Month strar's Signature State Registra

State of Maryland / Department of Health and Mental Hygiene 2 0 0 14 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Rollins Month 1240 P M NICOle **Physician** crystal 2004 DEC /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK 1552 Dockside DRIVE FREDERICK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Z - Z 6 5. Social Security Number 6. Sex **Funeral** 1□M 2ØF Days Hours 212-86-4989 29 Yrs. MD. Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County rthan "natural", or items 23a or 28a-f show the Modical Examiner must be notified at 1 Yes 2 No MO. FREDERICK FREDERICK Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number DRIVE DOCKSIDE 21701 U. S. A. 1552 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 Z No Specify. Baltimore, Maryland 21215-0036 Specify: BLACK δ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) WELLS FARGO Elementary/Secondary (0-12) College (1-4or 5+) CLAIMS MORTGAGE 3 YRS. marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental H filem 27 is marked oth LAYER JEAN ROLLINS WARREN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and important: if Item 27 is m sny injury or other traum once. JEAN ROLLINS (MOTHER) WALKERSVILLE MO, FORESIGHT LANE 8424 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) DEC. 30, 2004 FREDERICK MD. FAIRVIEW COM. 22. Name and Address of Facility

GARY C. ROLLING FUNERAL ITOME 21. Signature of Funeral Service Licenses lleus SOUTH ST FELDERICK MD 21701 WEST 110 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BREAST Immediate Cause (Final disease or condition resulting in death) METASTASES **Physician** ANCEK 0 804 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed ig physicien and as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? be detached for 5 ☐ Other (specify) 4 Pregnant at time of death the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 Yes 20 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? Yes 2 No page 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation within 24 hours after death. To the Funeral Lirector: A 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) LEDICAL DIRECTOR 29c. License number 29b. Signature and title of certifier D 10587 muth, 19.0 Jerson who completed cause of death (Item 23a) (Type, Print) Hostics of CUUNTS FREDERICK 576 TRAIL AUS. 14.0. MEDICAL DINECTOR GEO RGE SMITH 31. Date filed (Month 22 Year) 8 32. Redistrar's Signature 2004 Registrar

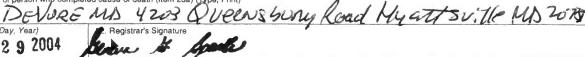
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 22, 2004 Year **Physician** 3:02 A. M Cordelia A. M. Seldon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months 1 □ M 2 🖸 F 72 Director 577-46-6239 February 12, 1932 Virginia Usual Residence of Decedent 2 should be illed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "natural", or Itame 23a or 28a-1 ehow 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examinar must be notified at Maryland Greenbelt Prince George's 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. #202 20770 7710 Hanover Park Way U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 25 Married 1 ☐ Yes 2 No Specify: þ Black Specify: 3 ☐ Widowed 4 ☐ Divorced Completed traumatic evant, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h. Kind of Business/Industry (Specify only highest grade completed) Prince George's County College (1-4or 5+) Elementary/Secondary (0-12) Public School System School Teacher 6 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental I Joseph Patton Dorothy Brown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health it Norris G. Seldon (Husbard) 7710 Hanover Park Way Greenbelt, Maryland 20770 Act. 202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, State Department of Important: If It any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans' Cemetery December 30,2004 Cheltenham, Maryland 22. Name and Address of Facility Rollins Fureral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 23a. Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cell Carginoughung **Physician** disease or condition resulting in death) Non Small /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 100 been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2010o certificate 1 Yes 2🏋 No 1 ☐ Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 SER/Outpatient 3 DOA 2 this æ 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Maccident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 M Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year) DEC 2 9 2004

Name and address of person who completed cause of death (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 12:45 P^M SOKOLOV DEC. 23, 2004 **JOSEPHINE** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY CHEVY CHASE 555 FRIENDSHIP BLVD. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1□ M 2 😿 F Yrs. 28, 1913 **CANADA** Director 379-46-3591 90 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show The Medical Examiner must be notified at 1 Yes 2 No Director CHEVY CHASE MD. MONTGOMERY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 or Items 23a U.S.A. 20815 555 FRIENDSHIP BLVD. Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after ☐Yes 2 No f Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: þ 3X Widowed 4 ☐ Divorced WHITE 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER HOME 4 other permit, Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: It item 27 Is marked other any injury or other traumatic svent, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SALTZMAN ADA SCHRIEBER **JOSEPH** 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 41st ST. N.W., WASHINGTON, D.C. 20015 ADA JO MANN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 12-24-2004 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MONTHS Priysician INANITION /Medical Due to (or as a consequence of). Examiner YRS. DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit be executed Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the IF FEMALE: 980 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 **X** No 4□Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 ☐ Yes 2x No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3 DOA 5 y esidence 6 □Other (Specify, his Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 Tyes 2 □No after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner s 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier vun D39456 DEC. 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 WISCONSIN AVE. #1400, CHEVY CHASE, MD. 20815 McCONNELL, M.D. LILA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DFC 27 2004 Registra

			For State Registrar		State o	f Marylan		artment of I		and Mer		jiene leg. No.	004	4251	+7
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	Examin		4a. Facility Name (If not insti	tution, give s	street and nur	n <i>ber)</i>	_	4b. City, Town,	or Location of	f Death		4c. 0	County of Dea	th	
			12505 Two F	arm Dr	ive			Silve	Spri	ng		M	ontgom	ery	
	Funeral		5. Social Security Number	6. Sex	M 2⊠F	7. Age (In yrs.	• • • • • • • • • • • • • • • • • • • •	If Under 1 Year Months Days	If Under 2 Hours		Date of Birth (Month, Day	Year)	9. Bir	thplace (State or Fountry)	oreign
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	and		Usual Residence of Deceder 10a. State 10b. Co			10c. Cit	ty, Town or Lo	ocation						10d. Inside City I	Limits
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	the 286	Directo	10e. Street and Number	n e gome			LIVOI	10f. Zip Code				10g. Citiz	en of What Co	ountry?	
	3e or	<u> </u>	12505 Two F	arm Di	rive			2090)4			U.	S.A.		
	ms 2	Funeral	11. Marital Status		12. Was Dece	edent Ever in U	.S. 13.	Was Decedent of	lispanic Orig	gin? (Specify	y Yes or No-	1-	4. Race - Ame		
9	or ite	F	1 ☐ Never Married 2 🛛	Married	Armed Fo 1 ☐ Yes If Yes, Giv	2 🔀 No		1 ☐ Yes 2⊠ No		, rueno nic	an, etc.)		Black, White Specify: W		
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ary	S E E	-	19a. Informant's Name/Rela	tionship (Ty	pe, Print)		19b. Maili	ng Address (Stree	and Number	r or Rurai R	oute Numbe	r, City or	Town, State,	Zip Code)	
	s 1 and 2 of Health a litem 27 is other tree		Vincent Paul	Sava	ge/Husl	band	1250	5 Two Fa	rm Dri	ve, S	ilver	Spri	ng, MD	20904	
J. C	of He of He fiterr roth		20a. Method of Disposition 1 Burial 2 □ Crema	tion 3 🗆 🗆	lamoual from		Place of Dispo cometery, crea	osition (Name of matory or other pla	ce)	Date		20c. Loc	ation - City or	Town, State	
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•	5		James	Le. P	200	er, M	U	D-07	285			Dece	mber 2	1, 2004	
			30. Name and address of po												
			James A. Br							Suite	#300,	Roc	kville	, MD 208	50
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			1 - For State Registrar	State of Maryla	nd / Depa	artment o	f Health and of Death	Mental H	ygierze 0 0 L	e. 42548
	Physic /Medi Exami	cal	Decedent's Name (First, Middle, La.	loysius Sto			n, or Location of De	2. Date of D Month Decem	_	
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	th the Marylan or 28a-f show e notified at	irector	10a. State 10b. County Maryland Queen 10e. Street and Number		ity, Town or Lo ueen An		le e		10g. Citizen of Wha	10d. Inside City Limits 1 □ Yes 2 □ No t Country?
900	d within 72 hours after death with the Maryland Jione. r than "natural", or itema 23a or 28a-f show If a Musical Exeminer must be notified at	d by Funeral Director	Main Street 11. Marital Status 1 □ Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1		of Hispanic Origin? (cuban, Mexican, Pue	Specify Yes or Nerto Rican, etc.)	United St Americ o- 14. Race - / Black, v Specify:	ates of
Maryland 21215-0036	d within giene. rr than "	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 11 HS Grad	ucation de completed) College (1-4or 5+)	(Give	ent's Usual Ockind of work do NOT use rel	ne during most of w tired) er		16b. Kind of Busine	ess/Industry
Aaryland	a la b y	To Be	17. Father's Name (First, Middle, Last) Percy Clint 19a. Informant's Name/Relationship (7		19b. Mailin	g Address (Stre	Mart	ha Aloys	e, Maiden Sumame) Sius Skinne Der, City or Town, Stat	er
Baltimore, A	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marke any Injury or other traumatic <u>once.</u>		Mary Teressa Stoo 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	Place of Dispos cemetery, crem	sition (Name of atory or other p	efeca)	ne, Mary Date 21/04	land 2165	
Balt	permit. Departr Imports any Inji		21. Signature of Funeral Sérvice Licentes 23a. Part 1. Enter the disease, or compshock, or heart failure. List only compshock.	and nest)9 M	Name and Add OORE F	dress of Facility uneral I h Second	Home, P d Stree	.A. t. Denton	21629 Maryland
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P.O. Box 6	The law requires that the death certificate be executed te has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3 □	Ectopic pregnar Other (specify)			23d. Date of Month	delivery Day Year
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			30. Name and address of person who co		23а) (Туре, Рг	int)			12-17-	
İ	Stat Registra		H. Laura Jin, M.D. 31. Date filed (Month, Day, Year)	32. Registrar's Signat	n Wash		, Street	t, East	on, Maryla	and 21601

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STOOFS, MARION A

			for State Registrar	. 10400	State of M		Depa	artment o	of Heal	th an		al Hygie		004	42	549
	Dhusis		1. Decedent's Name (F	irst, Middle, Last)							ate of Death	Day	Year	3. Time	e of Death
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	land ow			b. County		10c. City, Tow	vn or Lo	cation							10d. Inside	e City Limits
	Mary -f sh	to	Maryland	Carro	11	Мо	unt	Airy							1 □ Y	res 2X No
	r 288	Director	10e. Street and Numbe	r				10f. Zip Co	de			100	g. Citizer	of What Co	untry?	
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Examinar must be notified at once.	þ	1 ☐ Never Married 3 🎇 Widowed 4 ☐		1 Yes 2 To 1 Yes, Give A Year or Dates:	No		1 Tes, specify 1 □ Yes 2 汉		ecity:	ruento nican,	, etc.)	Sp	Black, White ecify: [hite	
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and	od o ed o	Be	JOHN	,, 2001,	CAMI	20			75.1		ZABETH			VANI -		
2	hould d Me mark matic	2	19a. Informant's Name	/Relationship /Ti			h Mailir	ng Address (St	treet and N						in Code)	-0
Maryland	d 2 s th an th an trisu				Daughter			Heaven					-		2177	<i>,</i> 1
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Baltimore,	Pages nent of h ant: ff itu				Removal from State	9	-	natory or other		D-	- 20 (
ij	permit. Pag Department Important: I any injury o		' 4 ☐ Donation 5 [21. Signature of Funer			Curle		ills Me		De C	c. 30,	2004 Pa	alm	Harbor	, FIO	rida
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			show r heart fa	illure. List only o	ne cause on ea	5 e.		22120	· •, 9, •=•			y arros	*1		Interval i	
	Physician /Medical		disease or condition resulting in death)	ai 🖊	a	neun	ion	1a							day	15
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Ö	al or A safter I Dirac d in by	Certification;	4 Homicide	dotominod	building, e	itc."(Specify)					C	ity or Town,	State)			
	To tha Hospital or Attand within 24 hours after death To tha Funaral Diractor; completely filled in by the	Medical C	29a. Certifier 1 (Check only 2 one)	Certifying Phy Medical Exam	sician: To the bes iner: On the basis and manner s	of examination as	je, deatl nd/or in	occurred at the vestigation, in	he time, da my opinion	ate and p	place, and du occurred at t	ie to the cau he time, date	se(s) and and pla	d manner as ice, and due	stated. to the caus	e(s)
	To the within To the Comple	Me	29b. Signature and title	of certifier				29c. Li	icense num	nber	,	290	. Date s	gned (Month	, Day, Year) ./
	> - 0		> A01/	K				D	269	516	•		DF	C	23	2004
(3		30 Name and address	of person who c	ompleted cause of	death (Item 23a)	(Type,	Print)	1-1	1	1/ -	70-		1-16		- 050
	2)		HILEN 3	1. 61K	CM NO	14	25	741	1K/	1	re.	HKEP	CK	ICH 1	4D 2	1102
	Sta Regist	ate rar	31. Date filed (Month,	DECar2 7	2004 32. Regis	trar's Signature	4	And !	p							

			1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of F tificate of	lealth and <i>Death</i>		ien 2 0 0 4	42550
			1. Decedent's Name (First, Middle, Last))				2. Date of Deat Month		3. Time of Death
	Physicia /Medic		Joseph James Seri	.0				Decembe	r 22, 200	
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. Cily, Town, o	r Location of Dea	th	4c. County of De	ath
			Anne Arundel Medic			Annapol:			Anne Aru	
	Funeral		5. Social Security Number 6. Set	x 7. Age (In yrs. : 3 M 2□F 83	(ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min		Year)	irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	0.3				11/23/1	921 LO	uisiana
	/land		10a. State 10b. County	10c, Cit	y, Town or Lo	cation				10d. Inside City Limits
	Mar e-fst	į	Maryland Anne Arun	del	Crofto	n				1 □XYes 2 □ No
	th the	Director	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What (Country?
	within 72 hours after death with the Maryland ene. Than "ratural", or tlems 23a or 28e-f show the Marical Extraitor mast be mattle at a	Ta [2106 Chainbridge C			21114			SA	
	er deg	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. \	Was Decedent of H f Yes, specify Cubi	lispanic Origin? (i an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - An Black, Wh	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ₩ No If Yes, Give X Year or Dates:		1□Yes 2√∑No	Specify:		Specify:	White
21215-0036	tural	edt	15. Decedent's Edu		16a. Deced	dent's Usual Occup	ation		16b. Kind of Busines	
5	n n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wo d)	orking	United S	tates
2	giene giene er the	ĕ	12		Compu	ter Prog	rammer	D	epartment	of the Navy
g	al Hy al Hy d othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle, A	Maiden Surname)	
<u>ya</u>	Ment Ment arkec	ဥ	Frederick Serio				Rose Li			
Maryland	2 sho		19a. Informant's Name/Relationship (T)	/pe, Print)					City or Town, State	
<u>د</u>	and leaith im 27 her t		Vince Serio/ Son	20h E	-	Chainbrion (Name of	ige Court		Maryland 20c. Location - City o	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Health and H		20a. Method of Disposition 1 ◯XBurial 2 □ Cremation 3 □ F		emetery, crer	natory or other place	ce)			
Ē	it. Pa rtmer rtent njury		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 	1	Cemete	Park West	es of Eacility D		hreveport Evans Fun	, Louisiana
Ba	permi Depar Impo eny ir		21. Signature of runeral Service Licens						, Marylan	
			23a. Part 1. Enter the disease, or complete	lications that caused the deat						Approximate
	110000	0	shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line		11				Interval Between Onset and Death
1	Pnysician /Medical	6 1	disease or condition resulting in death)	a. Du ko (or as a conseq	om y	palh	4			+
П	Examiner			Anyla	1		,			
		je l	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq						
	cuted nd ransii	Examin	Cause. Enter Underlying Cause (Disease or injury that initiated events	с						
Ö,	ficate be executed physician and is the burial-transit	Ĕ	resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	cate b	dlcal		d						-
Φ	ding p	w	IF FEMALE:	23c. If yes, outcome of pregna	ancv				22d Date of d	oliven.
Вох	death certifii e attending p id for use as	Physician/M	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d	il death 3□	Ectopic pregnancy Other (specify)	1		23d. Date of d Month	Day Year
	the c y the chec	iyslo	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown						
σ.	res that igned by be deta	by Ph	Part II. Other significent conditions co	ntributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
rds	requires sen sign hould be							1 □ Ye	s 2000 3 🗆	Probably 4 Unknown
Record		Completed						24a. Was a		autopsy findings available completion of cause of
æ	a ~ B	E O						autops perform		
	ician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of De	eath (Check only on	- 1	
>	Physician: this certific ral director,	To	examiner?	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing	Home 5 ☐ Reside	nce 6 Other (Sp	ecify)
			27. Manner of Death Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe ho	w injury occurred	
sio	Attending r death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	20()		2 (0 + 1)
Division	of or Attencater death Director:	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif		eet, factory, office		City or Town	reet and Number or i i, State)	Hurai Houte Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	ledical C		rsician: To the best of my kno iner: On the basis of examina and manner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of certifier	* /		29c. Licens	e number	2	9d. Date signed (Mo.	nth, Day, Year)
	. ,,,,		· // - 7/2	MO		05	518	7	12/22	104
			30. Name and address of person who c	ompleted cause of death (Iten	n 23a) (Type,	Print	- N	111	0 1	C
			Aime	W		Hone	Bro	ndel 1	Tedica	1 Conter
	Sta Registi		31. Date filed (Month, Day, Year) DEC 2 7 2	32. Prégistrar's Signa	ature	back				

			1 - For State Registrar	State of Maryla		artment of H			giene 0 0 1	42551
			Decedent's Name (First, Middle, Last	st)				2. Date of De	ath	3. Time of Death
	Physici		Edna Frances Tay	lor Smith				Decemb	Day Yee	4 1030 M
S. E.	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of		4c. County of De	ath
			4005 Yarmouth Lan	e		Bowie			Prince	Georges
28.	Funeral		Social Security Number 6. S		s. last birthday)	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of Bir Min. (Mgnth, Da	th 9. B	irthplace (State or Foreign Country)
	Director		403-32-3112	7	8 Yrs.			Min. 03/06/	1926 Ken	tucky
	and *		Usuel Residence of Decedent 10a, State 10b, County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
	daryl f eho	ō	Marryland Dudnes C		owie					1 🛣Yes 2 ☐ No
	28a-	ect	Maryland Prince G	eorges b	OWIE	10f. Zip Code		T	10g. Citizen of What (Country?
	With Ba or		4005 Yarmouth Lan	Δ		2071	15		USA	,
	death ms 2;	Funeral Director	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H	ispanic Orig	in? (Specify Yes or No)- 14. Race - An	nerican Indian,
9	r Ital	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No		If Yes, specify Cuba	an, Mexican,	Puerto Rican, etc.)	Black, Wh	ite, etc.
93	al', c	by	3 Midowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. then "netural", or itams 23e or 28e-f ehow the Modical Examiter mat be notified at	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occupa	during most	of working	16b. Kind of Busines	s/Industry
2	ithin	n jdu	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	3)	•		
	led w lygier har th			2	Secre	tary	40.44		American	Red Cross
and	be fi	Be	17. Father's Name (First, Middle, Last)					's Name (First, Middle,	, Malden Sumame)	
3	J Mer J Mer nark	2	Roy Taylor 19a, Informant's Name/Relationship (E e o Octob	405 44-18			Burma		7. 0. 1.
Maryland	12 st h and 7 is r traur		Ann T. Peavler/ D					or Rural Route Numbers Crofton,		
	1 and Heall em 2 thar	1 2	20a. Method of Disposition		Place of Dispo	sition (Name of		Date	20c. Location - City of	
100	ages nt of t: If it		1 NBurial 2 Cremation 3	Removal from State	cemetery crea	natory or other plac ION C	(e)	27 2007		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itama 23e or 28e-f show any injury or othar traumatic event, the Medical Examiner must be notified at ance.	1 9	* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer			Gardens		Robert E.		lle, Maryland ral Home
Ba	Depariment of the post of the	Q J	De PKu	-				Road Bowie		
	<i>4</i> //		23a. Part1. Enter the disease, or com	plications that caused the de						Approximate
	Obvoision		shock, or heart failure. List only Immediate Cause (Final		1		4	140	÷ 7	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. HTTEN IS S		Ve Tryp	er 1 -	my ove Hea	VI 90860	yse.
*	Examiner		20 2020 202		,					
100		Jer	if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):					
	cutec nd ransi	Examiner	Cause (Disease or injury that initiated events	c						
0,	e exe ian a urial-l		resulting in death) Last	Due to (or as a conse	equence of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medical		d						
9	leath certifica attending ph I for use as th	Mec	IF FEMALE:							
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live birth 2 Fe	tal death 3	Ectopic pregnancy			23d. Date of d Month	elivery Day Year
0	the a	ysic	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	death 5L	Other (specify)				
٥.	that the death ed by the atte detached for		Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute	to the cause of death2
Records,	uires tha signed I Id be det	d by						101	Yes 2 No 3 1	Probably 4 Denknown
200	w requir been si should	Completed				-		24a. Was	an 24h Were	autopsy findings available
Re	The lav	E D						autop perfo	osy prior to death?	completion of cause of
B		ပ္ပ	25. Was case referred to medical				OO Plans	1 ☐ Yes		s 2 No
Vital		To Bo	examiner?	Hospital: 1 Inpatient 2	□ EB/Outpatier	nt 3 DOA Othe		sing Home 5 eesic		anifed
ō			27. Manner of Death	28a. Date of Injury	28b. Time o	28c. Injury	y at		how injury occurred	өспу)
on	Attending I r death. octor: After by the funer	ig ig	1. Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Worl M 1 □ '	k? Yes 2 ⊟N	0		
Division	Attendi	ifica	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of injury - At	home, farm, str	eet, factory, office		28f. Location (S City or Tov	Street and Number or F	Rural Route Number,
ā	s afte	Certification;	4 Normicide	building, etc. (Spec	uny)			City of You	wii, State)	
	To the Hospital or Attent within 24 hours after death To the Funaral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Ph	ysician: To the best of my k	nowledge, deat	h occurred at the tim	ne, date and	place, and due to the	cause(s) and manner a	as stated.
	the H the F the F	ledi	one)	and manner stated.	nation and or in					
	To To	Σ	29b. Signature and title of certifier	11.4		29c. License			29d. Date signed (Mor	
			Harvodo /	my so		400	5592	-/	recembe	~ 23, 2004
			30. Name and address of person what	200	em 23a) (Type,	Print)	1.0	(heir	1. A	123, 2004
			31. Date filed (Month, Day, Year)	32. Sigistrar's Sig	nature	1an yr	1-00	Cred &	L TAN	1 mod
	Sta		DEC 93		AL A	Committee 15				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 1 42552 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day December 24, **Physician** Schademan 2004 9:15 P M Betty Jane /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Frostburg St. Vincent de Paul Nursing Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 0 5 / 0 5 / 1 9 3 1 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 73 175-24-0251 Director Pennsylvania Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

Itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, It is Maryland Extra little in ust be notified. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Frostburg **Funeral Director** Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21532 USA 10701 Laurel Hill Drive 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Retail 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ethel F. . Vogel Schademan Joseph ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 10020 Piney Mt. Road, Frostburg, MD Ethel Hagen / friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland Crematory 12/27/2004 Cumberland MD 22. Name and Address of Facility Adams Family Funeral Home, MD* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 21502 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) End sture (momic obstructive distuse Two years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner ng physician and as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 1 No 9 ☐ Unknown Month Year Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 X No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 📈 No Cther: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No after death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a
To the Funeral I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Noneock 8h 00055325 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1/18 48 Turn WONSOCK SHIN MO Terrace 31. Date filed (Month, Day, Year) DEC 2 32. Registrar's Signature State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 🛭 🕦 👢 42553 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 26, 2004 **Physician** ELSA ENRICHETTA SQUILLARI 7:50 A. M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner CHARLESTOWN RETIREMENT COMMUNITY BALTIMORE BALTIMORE 8. Date of Birth (Month, Day, Yeer) JAN• 26,1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 X F 212-38-6084 80 Director ITALY Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at MD ALLEGANY CUMBERLAND 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1034 FREDERICK STREET 21502 items 23a U.S.A. Pages 1 and 2 should be filed within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: WHITE þ X□ Widowed 4 □ Divorced "natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 then College (1-4or 5+) and Mental Hygiene. SEAMSTRESS CLOTHING FACTORY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fit Department of Health and Mental H Important: If Item 27 is marked out any injury or othar traumatic even 9068. Be ANDREA VIRGINIA ROSSO BERTOLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WALTER SQUILLARI SON 1834 RALSTON COURT, CROFTON, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Parial 2 ☐ Cremation 3 ☐ Removal from State SS.PETER & PAUL CEM. 12/29/2004 CUMBERLAND, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses ²²UPCHURCH³⁵FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD DERLINC 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ment 10 P CIL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, It ary, leading to infiliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): burial-1 Box 68760, physician Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. 1 ed by the a 9 Unknown 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No cate has autopsy perform certificate 1 Yes 280 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Yeer) 27. Manner of Peath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1-Natural 2 Accident death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ŏ Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) MD De cank 26, 2004 4 30. Name and address of person/who completed cause of death (Item 23a) (Type, Print) 017515 (9,04 Morida 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiegle [] [1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JAN 8 Day 2004 **Physician** 12:16 BABY BOY SHARP /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1₩ 2□F Hours 3 Yrs. N/A Director JAN 7 2004 MARYLAND Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "natural", or Items 23e or 28e-f show treumetic event, the Medical Examiner must be notified at 1X Yes 2 No Director VA FAIRFAX FAIRFAX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11841 FEDERALIST WAY APT 1 22030 UNITED STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc hours after 2 💢 No 1 X Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ WHITE 3 Widowed 4 Divorced Year or Dates: "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi and Mental F is marked ot GERALD BENITO SHARP SHELICE ALLYN CARLBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it. Pages 1 and 2 slutment of Health an ortent: If item 27 is 1 other t GERALD B. SHARP 11841 FEDERALIST WAY APT 1 FAIRFAX VA 22030 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 0 ^ 4

Donation 5

Other (Specify) 02-25-04 NAME BEMESTO MD NAME BETHESDA MID permit.
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Importe
eny inje 21. Signature of Funeral Service Licensee 22. Name and Address of Facility NINIAC Befresde MID arma oone 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PREMATURITY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ္ 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 1 Xnpatient this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. unerel Director: A investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 048338-2 (PA) X aurel 30. Name and sess of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER MAUREEN TATE LTC MC USA BETHESDA MD 20889-5600 31. Date filed (Month, Day, Year) 32. Reginar's Signature State 2005 Registrar

Amend item#23e, perMI, G839, 1.25.05 III

1- For Amend Items 25,26,27 per Dr., G839, 01/11/05dhb

Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month Year **Physician** ELIZABETH NICOLL SEGRAVES 17, Dec. 2004 4:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 K F Months Days Hours Min. Yrs. 214-18-3494 **Director** 89 <u>Pennsylvania</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show wat be nutified at 1 ☐ Yes 2 No Directo MD. Harford Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 2618 Houcks Mill Road 21111 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: or other traumatic event, If a Mudical Example ģ If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Quality Control Medical ges 1 and 2 should be filad void of Health and Mental Hygie If item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Austin Price Nicoll ပ Carrie Houseman 40/11/2/2000 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miles W. Segraves/Husband 2618 Houcks Mill Rd. Monkton, Md. 21111 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12721 Pages 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Departmant o Importent: If ' 4 ☐ Donation 5 ☐ Other (Specify) injury Bel Air Mem. Garden 2004 Bel Air, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1ETABOLIC Physician ACIDOSIS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): death certificate be Physician/Medical the as Box IF FEMALE usa 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) the Records, P.O. detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Flobably 4 Unknown 1 ☐ Yes 2X No 3 Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No. 2 Vital 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: To the Hospital or Attending 1 Natural 2 Accident Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide atter within 24 hours a To the Funeral E Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 26344 cause ath (Item 23a) (Type, Print) CHESAPEAKE MEDICAL CENTER PPER 32. Registrate Signature State 10 alexan

Registrar

Elizabeth

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	/Medic Examin		4a. Facility Name (If not institution, g				4b. City, Town, or	Location of		4c. County of Dea	
			5503 Linwood (·			Lanha			George's
	Funeral Director			3. Sex 7. <i>I</i> 1 □ M 2 □ X F		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Day		rthplace (State or Foreign ountry)
			578-12-1907 Usual Residence of Decedent		86				Jan. 6,	1918 Nor	th Carolina
	arylan show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation	- 1			10d. Inside City Limits
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yla	ould by Ment	2	John Gi							e Morrison	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event. The Medical Examinet must be putilised at once.		19a. Informant's Name/Relationship		0.10					r, City or Town, State, MD 20706	Zip Code)
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alti	permit. Departm Importa any inju		21. Signature of Funeral Service Lic		PIL		. Name and Addres			uneral Hom	
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ı	4. Di		Decedent's Name (First, Middle, Last))						٨	ate of Dea	th Day	Yea	r	ime of Death
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	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Attencompletely filled in by the fune	edical	29a. Certifier 1 ☑ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best of	examina	wledge, deatl ition and/or in	h occurr vestigat	ed at the tir ion, in my o	ne, date and plac pinion, death occ	ce, and c curred at	the time, d	ause(s) late and	and manner place, and d	as stated. ue to the c	ause(s)
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	6+1		30. Name and address of person who co											-	
			Azher Hussain,				Ro	ad, C	ollege P	ark,	MD	207	40-143	9	
	Sta Registi		31. Date filed (Month, Day, Year) DEC 27 200	32. Registra	ar's Signa	Sture	1 de	tocks							

			1 - For State Registrar	State of Maryland / De	partment of Health and N Certificate of Death	Mental Hygi	ene 004	42558
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	/Medic		Eleanor Hertz Ta			Decembe		4 8:25 P M
	Examin	er	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
			Layhill Center 5. Social Security Number 6. Securi	x 7. Age (In yrs. last birthd	Silver Spring If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgom	ery hplace (State or Foreign
	Funeral Director			M 210 F 100 Yrs	Months Days Hours Min	Jul 7,	Year) Co	gary
_	ס		Usual Residence of Decedent			JUL / 9 .	1904 Hull	galy
	anylar show	<u>.</u>	10a. State 10b. County	10c. City, Town of	r Location			10d. Inside City Limits
	8a-f	Director	Maryland Montgo	mery Rockvi				1 ☐ Yes 2 No
	with t a or 2 ben	Ö	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Co	untry?
	leath	eral	14005 Bauer Dr	12. Was Decedent Ever in U.S. 1	20853 3 Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	USA 14. Race - Ame	ocan Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuryef other traumatic event, it a Madical Examination and pages.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	Rican, etc.)	Black, White	
Š	2 hou	ted	15. Decedent's Edu	cation 16a. De	ecedent's Usual Occupation	1	6b. Kind of Business/	
218	thin 7 e. an "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	ive kind of work done during most of work e. DO NOT use retired)	ing		
2	ed wi ygien nar th	Con	12	Sea	mstress		Dress Co	ompany
and	be fill	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, M		
ž	hould d Mer marke matic	2	Martin Hertz 19a. Informant's Name/Relationship (Ty	una Print) 10h M	Mathild: Address (Street and Number or Run	Rosenfe		7- O- d-1
Maryland 21215-0036	d 2 s th an t7 ls i traui							ip Code)
ē,	s 1 ar f Hea itam 3		Stanley Talmud/S 20a. Method of Disposition	20b. Place of Dis	9005 Bauer Dr. Rocks		Oc. Location - City or 7	Town, State
ê E	Page ent of		1 X Burial 2 ☐ Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	orematory or other place) Hill Hebrew Dec 2	26, 2004	York, PA	Δ
Baltimore,	mit. partm porta y inju		21. Signature of Funeral Service Licens	1 Doddin 1	22. Name and Address of Facility Hit			
m	permi Depar Impor any ir		Mary	Donnell	11800 New Hampshire			
F	Dhusisian		23a. Part1. Enter the disease, of compleshock, or heart failure. List only or Immediate Cause (Final		enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Respira Due to (or as a consequence of):	tory Failure			
	Examiner			Paulemor	iia			
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	is after Kerle			
	ecuted ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	·				
60,	be ex cian a	E	resulting in death, East	Due to (or as a consequence of):				
68760,	ificate be executed g physician and as the burial-transit	edical		1				
P.O. Box (attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2∑□ No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (s <i>pecify</i>)		23d. Date of deli-	very Day Year
	that the ded by	h h	Part II. Other significant conditions cor	ntributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ords	w requires that the de been signed by the should be detached	ted by	Diabetes	Mellitus type II		1 🗆 Yes	; 2 □ No 3 □ Pro	bably 4X Unknown
Division of Vital Records,		Completed				24a. Was an autopsy performe	ed? prior to co	opsy findings available ompletion of cause of
Vita	Attanding Physician: The death. actor: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		(Check only one,)	
ot	ys dis	2 :	1 Yes 2 No	28a. Date of Injury 28b. Time	- At -		ce 6 Other (Spec	ify)
on	ding h. After funer	tion	1 Natural 5 Pending	(Month, Day Year)		28d. Describe how	rinjury occurred	
/ISI	Attandi r death. actor: A by the fu	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm,			et and Number or Rui	ral Route Number,
	spital or Attanding Phous after death. aral Diractor: After th	Certification:	4 Homicide	building, etc. (Specify)		City or Town,	State)	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Physical Certifying Physical Control (Check only one)	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cau ed at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	2 0 0	29c. License number	290	d. Date signed (Month,	, Day, Year)
	6		Willam K	Legal .	D52261		December	22, 2004
	,		30. Name and address of person who co	impleted cause of death (Item 23a) (Typ	e, Print)			
			Alan R. Segal 15 31. Date filed (Month, Day, Year)	17 Hugo Cir, Silve 32. Registrar's Signature				
	Sta Registra	_	DEC 2 7 2004	4 Special Styllator	Sparks			

			1 - For State Ragistrar	State of Ma		ertificate of	lealth and Me		6000	42559
			nagistrar Decedent's Name (First, Middle, L.	ast)		minouto or		Reg. I	10.	3. Time of Death
	Physici /Medic		SALLYA.	TODD				Month [2_	ay 21 Year	0.210
	Examin		4a. Facility Name (If not institution, gi			4b. City, Town, o	r Location of Death		c. County of Dea	
			University OF	MARYLAND			LTIMORE		BALTI	
н	Funeral			Sex 7. Ag 1 ☐ M 2 【 ☐ F	e (In yrs. last birthday 51 Yrs.	Months Days	Hours Min.	1. Date of Birth 1. Day Y5°	KI (thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent					10/01/5	riai	yland
	yland		10a. State 10b. County		10c. City, Town or L	ocation		1		10d. Inside City Limits
	Mar.	tor	MD Dorch	ester		Rhodesd	lale			1 ☐ Yes 2√GxNo
	ih the or 284 groot	Director	10e. Street and Number			10f. Zip Code		10g. (Citizen of What C	ountry?
	11 wi		6230 Church F	lome Road			21659	U	nited S	States
036	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow dical Exaction must be profit of at	by Funerai	11. Marital Status 1 TxNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	tispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Am Black, Whi Specify:	
9	72 hours a 'natural', o dical Exac	ted	15. Decedent's E (Specify only highest g	ducation	16a. Dec	edent's Usual Occup	ation during most of working	16b.	Kind of Business	/Industry
21	l within 7. jiene. r then "n	Completed	Elementary/Secondary (0-12)	College (1-4or	(ife.	DO NOT use retire	d)		astic F	roduction
21	e filed wi Il Hygien other th	5	12		Mac	hinist				TOGUCCION
Maryland 21215-0036	0 0 0 0	To Be	17. Father's Name (First, Middle, Las George Todo				18. Mother's Name (en Sumame) ckson	
ary	de principal	-	19a. Informant's Name/Relationship	(Type, Print)		-	and Number or Rural i			
	1 end 2 Heelth a tem 27 is		Annie M. Jacks	on/Mothe	r 623	O Church	Home Rd	., Rhod	esdale,	MD 21659
nore	0 0		20a. Method of Disposition 1 Burial 2 □ Cremation 3 i 4 □ Donation 5 □ Other (Spec			position (Name of permatory or other plants 1111 (9/04 Fe	Location - City or deralst	
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lice		1	22. Name and Addre	iss of Facility Francis	mptom F	uneral	Home, PA MD 21632
			23a. Part1. Enter the disease, or cor	nplications that ceused					sburg,	Approximate
4	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	11	ne. SCHEMIC		DIOMYOPA			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	•	a consequence of):					
	nsit	niner	Sequentially list conditions, if any, leading to immediate dece. Entail United his Cause (Disease or injury that initiated events	b. Due to (or as	a consequence of):					
50,	cate be executed obysician and the burial-transit	i Examin	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					
8760,	ate hy: the	dicai		d.						
.O. Box 6	at the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy	/		23d. Date of de Month	livery Day Year
Ω.	quires that in signed by	þ	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause giv	en in Part I.		. /	o the cause of death?
Records,	The law requires that ate has been signed b page 2 should be deta	Completed						24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?				26. Place of Death (
of V	Physic this ce al dire	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	ent 2 ER/Outpatie	ent 3 DOA Oth	er: 4 Nursing Home	5 🗆 Residence	6 ☐Other (Spe	ocify)
n c		on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time Injury	Wor	k?	d. Describe how in	ury occurred	
Sio	ten leat tor: the	cat	2 Accident investigation 3 Suicide 6 Could not	ne -			Yes 2 □No	() a tia - (0)		
Division	i Sirie	Certification:	4 Homicide determined	289. Place of III	ury - At home, farm, s c. <i>(Specify)</i>	treet, factory, office	28	City or Town, Sta		ural Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysician: To the best miner: On the basis o and manner st	f examination and/or i	th occurred at the tir nvestigation, in my c	ne, date and place, an pinion, death occurred	d due to the cause at the time, date a	s) and manner a nd place, and du	s stated. e to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier) (29c. Licens			ate signed (Mont	,
			1 the	é 1	MD.	PC	15881	12	/21/04	
			30. Name and address of person who AHDREW OSUC		leath (Item 23a) (Type S. GREENE		TIMENT, MI	> 31301		
	Sta Registr		31. Date filed (Month, Day, Year)-	ARTIN	ar's Signature	4	1			
	negisti	ar	DEC 2 9	2004 1 1985	100 Nr. 3	Coast s				

		•	1 - For State Registrar	State of Ma		partment of H Certificate of L		Reg	2004 2004	42560
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, the Charles 4a. Facility Name (If not institution, g	Joseph	1	Thompson	Sr.	2. Date of Death Month Decembe	Day Year 27, 200	
	Funeral	51		Sex 7. Ag	e (In yrs. last birthd	(ay) If Under 1 Year Months Days	berland If Under 24 Hrs. Hours Min.	8. Date of Birth		thplace (State or Foreign ountry)
	Director		723-14-4139 Usual Residence of Decedent 10a. State 10b. County MD A 11	egany	10c. City, Town o	r Location		09/03/19	928 We	St Virginia 10d. Inside City Limits 1□Yes 2∑No
	with the Mi 3a or 28e-f	i Directo	10e. Street and Number	imore Pike	1	berland 10f. Zip Code 21	502	100	p. Citizen of What C	
980	within 72 hours after death with the Maryland ene.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:	Ever in U.S. No 1951 - 1953	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
21215-0036	d within 72 ho giene. or then "natur the Medical	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 1 2	Education grade completed) College (1-4or 5	(G	ecedent's Usual Occup ive kind of work done of fe. DO NOT use retired Laborer	ation during most of work)	ing 16	Sb. Kind of Business Tire and	
Maryland	hould be file d Mental Hyg narked othe natic event,	To Be C	17. Father's Name (First, Middle, La Glen 19a. Informant's Name/Relationship		Thompson	ailing Address (Street	Kathle		Laugh	lin
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if them 27 is marked other then "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		Michael E. Thom 20a. Method of Disposition 12. Burial 2 Cremation 3 4 Donation 5 Other (Spe	pson / son Removal from State	91. 20b. Place of Dicemetery,	5 Camden Av sposition (Name of crematory or other place Cem @ Roc 22. Name and Address	venue, Cu e) ky Gap 12 ss of Facility Ac	mberland. Date 20 2/30/2014 lams Fami	MD 2150 c. Location - City of Flintst ly Funera) 2 Town, State
	Physician /Medical Examiner	Iner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, If any learning to mine the cause. Enter Underlying Cause (Disease or injury)	a. Change on each lie	d the death. Do not ne.	enter the mode of dyin	g, such as cardiac			Approximate Interval Between Onset and Death
Box 68760,	leath certificate be executed attending physician and for use as the burial-transit	n/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	d	a consequence of): of pregnancy 2 Fetal death	3 □Ectopic pregnancy			23d. Date of de	livery
P.O. B	at the deatl by the attestached for	hysicia	in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pregnant at 9□ Unknown	t time of death	5 Other (specify)			Month	Day Year
Records, I	law requires that the death certifica as been signed by the attending pr 2 should be detached for use as th	Completed by Physician/Med	Part II. Other significant conditions Diabetts tre	contributing to death b	ut not resulting in th	e underlying cause give	en in Part I.	Yes	2 No 3 P	o the cause of death? robably 4 □Unknown
Vital Rec	en: The law tificate has lor, page 2 s	0	25. Was case referred to medical	11000	10000		26. Place of Deal	24a. Was an autopsy performe 1 Yes 2.	prior to	utopsy findings available completion of cause of
Division of Vi	To the Hospital or Attending Physicien: The law within 24 hours atter death, within 24 hours atter death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	ToB	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat	28a. Date of Inju (Month, Da	ent 2 ER/Outpa ry 28b. Tim y Year) Inju	e of 28c. Injury	er: Nursing Ho	ome 5 Residence 28d. Describe how		ecify)
Divis	spitel or Att tours after de nerel Directe filled in by th	al Certification;	3 Suicide 6 Could not determine 29a. Certifier	building, et	c. (Specily) of my knowledge, d	, street, factory, office eath occurred at the time	ne, date and place,	28f. Location (Stree City or Town, S	State) se(s) and manner a	s stated.
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Exone) 29b. Signature and title of certifier	aminer: On the basis of and manner sta	f examination and/o	r investigation, in my op	pinion, death occur a number	red at the time, date	and place, and due Date signed (Month 27, 2	th, Day, Year)
7/2	I VA		30. Name and address of pers wr	o completed cause of d		pe, Print)	33250			
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	Sparks			22302	

		1- State of Maryl		rtment of Health and tificate of Death	Mental Hygie	21114	2561
Dhusia		Decedent's Name (First, Middle, Last)			2. Date of Death	Day Your	Time of Death
Physic /Medi	cal	Gordon Buford	,	Thompson	December	28, 2004	1940 M
Examir	ner	4a. Facility Name (If not institution, give street and number) Allegany County Nursing & Re	hab Ctr.	4b. City, Town, or Location of Dea Cumberland	th	4c. County of Death Allegany	
Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min			(State or Foreign
Director		374-18-3467 1⊠M 2□F 83	Yrs.	Months Days Hours Min	10/04/19	21 Missour	ri
/land low		Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Loc	eation		10d.	Inside City Limits
e Man a-fsh	ctor	MD Allegany	Cumb	erland			1∰Yes 2∏No
death with the Maryland me 23a or 28a-f show Livest be notified at	Funeral Director	10e. Street and Number 10 North Liberty Street		10f. Zip Code 21502	10g.	Citizen of What Country?	
death me 23	eral	11. Marital Status 12. Was Decedent Ever	in U.S. 13. V	Vas Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American li	ndian,
OTC, INICITY INICITY A LATE 13-0050 Jes 1 and 2 should be filed within 72 hours after death with the Marylan to Health and Mental Hygiene. If item 27 is marked other then "neturel, or iteme 23a or 28a-1 show other treumatic event, the Madical Examiliar Initial Participal at	by Fur	Amed Forces? 1 □ Never Married 2 □ Married 1 ☒ Yes 2 □ No1 9 If Yes, Give Year or Dates: 1 9	942-	Yes, specify Cuban, Mexican, Puer Yes 2 No Specify:	to Rican, etc.)	Black, White, etc. Specify: W	nite
2 hou	ted	15. Decedent's Education	16a Deced	ent's Usual Occupation	166	. Kind of Business/Industr	
ithin 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		tind of work done during most of wo O NOT use retired)			
filed w Hygier Other th		9 17. Father's Name (First, Middle, Last)	Pos	tal Carrier	me (First, Middle, Maid	.S. Postal S	Service
aryidation Z IZ should be filed with nd Mental Hygiene, marked other the umatic event, the	To Be	Lytle Othnal	Thomp			- '	nnis
i, INCIT) and 2 sho salth and 1 n 27 is ma		19a. Informant's Name/Relationship (Type, Print) Alice E. Shober / friend		Address (Street and Number or R Frederick Stree		, , , , , , , , , , , , , , , , , , , ,	(e) 502
of Health of Health if item 27 is			0b. Place of Dispos	ition (Name of atory or other place)	Date 20c	. Location - City or Town,	State
Pages ment of lieutry or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State • 4 ☐ Donation 5 ☐ Other (Specify)		d Crematory 12/		umberland, N	
permit. Pages Department of Importent: If is eny injury or once.		21. Signature of Funeral Service Licensee	22.	Name and Address of Facility A 404 Decatur Str		y Funeral Ho rland, MD 2	ome, P.A. 21502
		23a. Part1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.	death. Do not ente	r the mode of dying, such as cardia	c or respiratory arrest,	Inte	proximate prval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- Obi	tometrice for	ng Dise	ary Jons	Set and Death
Examiner		Due to (or as a con	isequence of):		l		
led	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nsequence of):				
o, execu an and rial-tra	Exar	that initiated events resulting in death) Last C. Due to (or as a con	nsequence of):				
ficate be executed physician and sthe burial-transit	edicai	d					1
nding use as		IF FEMALE: 23c. If yes, outcome of pregnant		21		23d. Date of delivery	
The law requires that the death certifier that been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		Month Day	Year
that the ed by detac		Part II. Other significant conditions contributing to death but not	t resulting in the un-	derlying cause given in Part I.	23e. Did tobacc	o use contribute to the ca	use of death?
quires an sign	ed by	Carevnoma of The	Prosto	to won	1 🗆 Yes	2 □ No 3 Probably	4 Unknown
law re as bee 2 sho	Completed	leone metasta	201.		24a. Was an autopsy	24b. Were autopsy fi	indings available
The cate his page	Com				performed	death?	
vitcien: certific rector,	Be	25. Was case referred to medical examiner? Hospital:		Othon	ath (Check only one)		
Phys er this eral di	. To	27. Manger of Death 28a. Date of Injury	2 ER/Outpatient 28b. Time of	3 DOA 4 Nursing F 28c. Injury at Work?	lome 5 Residence 28d. Describe how in	6 ☐Other (Specify)	
tending eath. or: Aftu	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No			
el or At	Certification:	4 Homicide	At home, farm, streen secify)	et, factory, office	28f. Location (Street City or Town, St	and Number or Rural Rou ate)	ite Number,
To the Hospitel or Attending Physicien: The law within 24 butus after death. To the Funeret Director: Attent his certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my 2 Medicel Examiner: On the basis of exam and manner stated.	knowledge, death mination and/or inve	occurred at the time, date and place estigation, in my opinion, death occu	e, and due to the cause arred at the time, date a	e(s) and manner as stated. and place, and due to the	cause(s)
To the within To the comple	Me	29b. Signature/and title of certifier		29c. License number	29d. l	Date signed (Month, Day,	Year)
3/1110		1 Monstrano 4 14	mera (1 2-14806	5 15	2-30-04	
MIL		30. Name and address of person who completed cause of death (Robustiano J. Barrera, M.			uo Cumbo-	land MD 04	F.O.2
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Si		ı	ue, cumber	rand, MD 21	.502
Registr		DEC 3 0 2004	D A	carty/			

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Box 68	
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Il Recor	
n of Vita	
Division	

منتور		State Registrar		Ce	ertificate of D	Death	Rec	. N2 004	4256
		Decedent's Name (First, Middle, I	.ast)				2. Date of Death Month		3. Time of Deat
Physicia /Medic		Leonard H.	Wade				December	23 200	
Examin	- 1	4a. Facility Name (If not institution, g Pen INSUCA RAJION	/	1 Centre	4b. City, Town, or L	Location of Death		4c. County of De	ath MICO
Funeral Director		5. Social Security Number 6. 215–22–8699 Usual Residence of Decedent	1X1M 20 E	(In yrs. last birthday 78 Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) October 14	(ear) 9. B (1926 Ma	irthplace (State or For Country) ryland
show at at	ō	10a. State 10b. County		10c. City, Town or L					10d. Inside City Lin
or 28a-f e notiffi	Director	Maryland Wicomi 10e. Street and Number	CO	Salisbu	10f. Zip Code		100	J. Citizen of What C	1
1 23e	ral	6312 Oxbridge Dr			21801			JSA	
it of Health and Mental Hygiene. If item 27 is marked other then "netural", or items 23e or 28a-f show or other traumatic event, the Mudical Examinar must be notified at	교	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ender Armed Forces? 1 X Yes 2 No	ver in U.S. 13. Navy	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☑ No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh	
ural',	d by	3 X Widowed 4 ☐ Divorced	Year or Dates:	WWII				W	hite
e. en "net Medica	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		(Give	edent's Usual Occupat e kind of work done du DO NOT use retired)	tion I <i>ring</i> most of work	cing 16	b. Kind of Busines	s/Industry
and Mental Hygiene. Is marked other then aumatic event, Ing M.		12 17. Father's Name (First, Middle, La		·	esman	19 Mother's Nam	e (First, Middle, Ma		tion Equip
Mental Parked of	m		31)					iden Sumame)	
nd Me mark matic	ဥ	Leon H. Wade 19a. Informant's Name/Relationship	(Type, Print)	19b Mail	ing Address (Street ar		oehlmann	City or Town State	Zin Code)
alth ar 27 Is r trau	1	Bruce Wade (son			East Clea				
if Hea item othe	-	20a. Method of Disposition		20b. Place of Disp				c. Location - City o	
nt: If	Ш	1 ☐ Burial 2 💆 Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		1	y Creamtor		er 28,2014	Salisbur	y, Marylan
Department of Health Important: If item 27 eny injury or other tr. once.		21. Signature of Funeral Service Lie	Margar (F)		Name and Address HOLLOWAY F				
		23a. Part1. Enter the disease, or co	mplications that caused the	he death. Do not en	501 Snow H. Iter the mode of dying,	such as cardiac	or respiratory arrest	iry, Mary.	Approximate
ysician		shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on each line)					Interval Between Onset and Death
Medical		resulting in death)	a	neumor	11 6				
		and the second s	Due to (or as a	consequence of):					
aminer		Sequentially list conditions	b	consequence of):		BENTE	TEALL	UNG	
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b (consequence of): CON G-CS consequence of):	STIVE	HEATE	TEALL	UNE	
	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	CON GES consequence of):		SERTE	TEAIL	UNG	
ician and burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	con Ges		BEAGE	TEAIL	UNG	
ysician and ie burial-transit	cal Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	CON GES consequence of):		SERGE	TEAIL	UNG	
attending physician and for use as the burial-transit	cal Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	b. Due to (or as a	consequence of): consequence of): pregnancy Fetal death 3[SERGE	TEAIL	23d. Date of de Month	Divery Day Year
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is been signed by the attending physician and 2 should be detached for use as the burial-transit	e Completed by Physician/Medical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	b. Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	consequence of): consequence of): pregnancy Fetal death feed death feed death	□Ectopic pregnancy □ Other (specify) underlying cause given	in Part I.	23e. Did tobac 1 ☐ Yes 24a. Was an autopsy performe	23d. Date of de Month coo use contribute t 2 \(\subseteq \text{No} \) 3 \(\supseteq \text{P} \)	Day Year to the cause of death? robably 4 AMARO utopsy findings availa completion of cause
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n 24 hours after death. Ne Funeral Director: After this certificate has been signed by the attending physician and pletely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	ledical Certification: To Be Completed by Physician/Medical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 27. Manner of Death 1 Yes 2 No 27. Manner of Death 2 Accident S Pending investigated 3 Suicide G Could not determine 29a. Certifier (Check only one) Certifying F (Check only one) (Check only one) Certifying F (Check only one)	b. Due to (or as a c. Due to (or as a d. d. 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown contributing to death but 28a. Date of Injury (Month, Day on be 28e. Place of Injury building, etc. Physician: To the best of aminer: On the basis of e	consequence of): consequence of): consequence of): pregnancy Fetal death 3[me of death 5[not resulting in the understand of the consequence of): 2 ER/Outpatien (Year) 28b. Time of linjury y - At home, farm, str (Specify) my knowledge, deat xamination and/or in	Dectopic pregnancy Other (specify) Int 3 DOA Cther. Int 4 DOA Cther. Int 4 DOA Cther. Int 4 DOA Ct	26. Place of Deatl 4 Nursing Ho at es 2 No , date and place, nion, death occurr	23e. Did tobace 1 Yes 24a. Was an autopsy performer 1 Yes 2 h (Check only one) me 5 Residence 28d. Describe how 28f. Location (Street City or Town, Stand due to the caused at the time, date	23d. Date of de Month coo use contribute t 2 No 3 P 24b. Were a prior to death? 1 Yes e 6 Other (Speinjury occurred et and Number or Ritate) se(s) and manner a and place, and du	Day Year To the cause of death? Trobably 4 Amino Trobably 4 Ami
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			For State Registrar	State of Mar			rtment of F tificate of			giene, Reg. No.	2004	42563
	Physici	an	1. Decedent's Name (First, Middle, L	.ast)					2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		Lydia		Wad	de			Decembe	er 18	8,2004	1511pm ^M
	Examin	er	4a. Facility Name (If not institution, g. Prince Goerges Co		nital		Cheverly	r Location of Death			County of Death Prince G	002200
	Funeral			Sex 7. Age	(In yrs. last bir	thday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Day		9. Birthp	lace (State or Foreign
	Director		239-60-0593	1□M 2\SF 77		Yrs.	Months Days	Hours Min.	Feb. 7	192	27 Norti	h Carolina
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	ation				1	0d. Inside City Limits
	Maryl -1 sho	tor	DC		Washi	nata	. n					MaYes 2 No
	h the or 28a encti	Director	10e. Street and Number		Wasiiii	ugec	10f. Zip Code			10g. Citiz	zen of What Coun	ntry?
	23a c	ralD	324 Bryant St. N	NE			20002				JSA	
9	should be filed within 72 hours after death with the Maryland of Mantal Hygiene. marked other then "naturel", or Items 23a or 28a-f show imatic event, the Medical Evaning must be notified at	y Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give			/as Decedent of H Yes, specify Cuba ☐ Yes 3, □ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - Americ Black, White, Specify:	
5-0036	hours turel'	ed by	3 Widowed 4 □ Divorced 15. Decedent's	Year or Dates:	162		ent's Usual Occup	ation			Blaci	
7.	n 72 n na n na	Completed	(Specify only highest g	rade completed)		(Give I	rind of work done O NOT use retired	during most of worki	ng	100. KII	id of business/inc	dustry
2121	filed with Hygiene other the	Com	8th	Coflege (1-4or 5+)		S	ecurity	Guard		Pr	rivate	
Maryland	buld be filed Mental Hygid arked other atic event, I	Be	17. Father's Name (First, Middle, Last Percy Wooten	st)				18. Mother's Name Betsey U		Maiden .	Sumame)	
Ž	should Ind Men	Ť	19a. Informant's Name/Relationship	(Type, Print)	19b	Mailing	Address (Street	and Number or Rura		r City or	Town State Zin	Code
	nd 2 :		Edna J. Cash/Dau	, , ,			k Creek		dison,			0020,
altimore,	Pages 1 and the pages 1 and th		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		cemeter	y, crem	ition (Name of atory or other plac [emorial		ate	20c. Lo	cation - City or To	
Balti	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Lice		\		Name and Addre	3011				eral Home
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	molications that caused the	te death. Do r			y St. NW g, such as cardiac o			рс 200.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a Cardiores								Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a	consequence							
L		-0	Sequentially list conditions, if any, leading to immediate b. G.I. bleeding Due to (or as a consequence of):									
	uted	Examiner	Cause (Disease or injury that initiated events	_{c.} Hypertens	ive Car	rdic	vascular	Disease				
Ö,	e exection and in an in an and in and in an an an and in an an and in an an and in an		resulting in death) Last	Due to (or as a				,				
68760	ficate be executed physician and is the burial-transit	edical	•	_d Dysphagia								
_			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy					2	3d. Date of delive	IN.
.O. Box	at the death by the atter tached for a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown			Ectopic pregnancy Other (specify)	·				Day Year
<u>a</u>	res that I igned by be deta	by Ph	Part II. Other significant conditions	contributing to death but	not resulting in	the un	derlying cause giv	en in Part I.	23e. Did to	bacco us	se contribute to th	e cause of death?
ıds	w require been sig should b								1 □ Y	es 240	INo 3 ☐ Prob	ably 4 □Unknown
Vital Records,	e la has je 2	Completed							24a. Was a autop: perfor	sy med?	24b. Were autop prior to con death? 1 \(\sum \) Yes	psy findings available npletion of cause of
īa		BeC	25. Was case referred to medical examiner?					26. Place of Death	1 ☐ Yes (Check only or			20,10
	Physic this or	ဂ္ဂ	1 ☐ Yes 2Ā No	Hospital:		-		4 Nursing Hor			Other (Specify)
Division of	ding Phy h. After thi funeral o	Certification:	27. Manner of Death 1. Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day)		rime of	28c. Injun Wor M 1	yat k? Yes 2 ⊡No	8d. Describe h	ow injury	occurred	
N S	or Attendi after death. Director: A in by the fo	ifica	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Injury	- At home, fa	rm, stre			28f. Location (S	treet and	Number or Rural	l Route Number,
ā	itel or A rs after el Direc led in by	Cert	4 Homicide	building, etc.	(эрөсну)			7	City or Tow	n, State)		
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific acmpletely filled in by the funeral director,	edical	29a. Certifier VCcertifying F (Check only one) 2 Medical Ext	Physician: To the best of aminer: On the basis of e and manner state	xamination and	death dor inve	occurred at the fin estigation, in my o	ne, date and place, a pinion, death occurre	and due to the dead at the time, o	ause(s) a late and	and manner as sta place, and due to	ated. the cause(s)
	within 2	×	29b. Signature and title of certifier	i .	0		29c. Licens	e number	2	29d. Date	signed (Month, L	Day, Year)
	(1820		· Quue	parmi	Ch L	LD	. D4549	90	I	Dece	mber 27,	2004
	Jak .		30. Name and address of person who Aruna Paspula, M					ly, MD 207	785			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	s Signature		2	-y , 201				
	Registr	ar	DEC 2 9 2004	Slew &	book	,						

_			1 - For State Registrar	State of M	Maryland	/ Depa	artment rtificate	of H	ealth a	and M		giene 04	42564
	Physici	an	Decedent's Name (First, Middle, Common		ilcox						2. Date of Dea Month	22, 2004 Yea	3. Time of Death
	/Medic	cal	George 4a. Facility Name (If not institution,				Ab Cib. 3	Tours or	Logation		December	4c. County of De	12:46 A. M
	Examin	er	Prince George's H		•		4b. City,	Che	verly	n Death		Prince Ge	
	Funeral Director				Age (In yrs. las	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day September	year) 9. E	Birthplace (State or Foreign Country) Georgia
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, "	Town or Lo	ocation						10d. Inside City Limits
	he Maryi 28a-f sho	Director	D.C.						Washiu	ngton ———		10-03	1 XYes 2 □ No
	with t	Dic	325 Division Ave	ne, N.E.			10f. Zip	Code	2001	9		10g. Citizen of What U.S.A.	Country?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hyglene. If item 27 is merked other then "netural", or Items 23e or 28e-f show or other traumatic avant, The Modical Exarilhetr hall be indiffied at	by Funerai	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceder	s? ⊒No		Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ar Black, W Specify:	
5-0	72 ho	eted	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usua	l Occupa	ition urina mos	t of workin	na	16b. Kind of Busines	
Maryland 21215-0036	ed within rgiene.	Completed by	Elementary/Secondary (0-12)	College (1-4d	or 5+)		kind of wor DO NOT us lerk	e retired,					Of Agriculture
yland	should be filt nd Mental Hy is markad oth	To Be	17. Father's Name (First, Middle, L Jim V	ast) VIICOX					18. Mothe	er's Name	(First, Middle, Marth	Maiden Sumame) a J. Barnes	
, Mar	and 2 sho ealth and n 27 is m		Mrs. Mary E. Wilcom			325 E	ng Address IVISIO	(Street a 1 Ave	nd Numbe	ľ.E. W	I Route Number ashington	i, B.C. 200	Gip Code)
Baltimore,	Pa in it		20a. Method of Disposition 1 ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑		cem	ne <u>t</u> ery, cre.	osition (Nam matory or ot oln Cent	her place	" Dec			Brentwood,	
Balti	permit. Pages Department of Important: If ii any injury or once.		21. Signature of Funeral Service L	icensee	in		2. Name and 1339 H.I					eral Home, l n, D.C. 2001	
	hysician and physician and physician and physician buriat-transit	Examiner	23a. Fa.1. Enter the disease, or of chock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Understying Cause (Disease or injury that initiated events resulting in death) Last	a. Cardia b. Cardia Due to (or:	as a consequent tive Hear as a consequent as a consequent tive Hear as a consequent as a consequent tive Hear as a consequent tive tive tive tive tive tive tive tiv	y Dise nce of): Imia nce of): rt Fai	ease	e of dying	g, such as	cardiac o	r respiratory arr	est,	Approximate Interval Between Onset and Death
O. Box 68760,	death certit e attending id tor use at	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 ☐ Fetal de t at time of deat	eath 3[□Ectopic pre					23d. Date of o	delivery Day Year
S, P.	uires that t signed by Id be deta	by	Part II. Other significant condition Pacemaker	s contributing to death	h but not resulti	ing in the u	inderlying ca	inse dise	n in Part I	10	23e. Did to	_	to the cause of death? Probably 4 □Unknown
Vital Record	The law requires that the rate has been signed by the page 2 should be detache	Completed									24a. Was a autops perfor	sy prior t	
ita	ysician: Th	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or	ne)	
of V	Physician: this certific ral director,	은	1 XYes 2 No	Hospital:		VOutpatie		_	4 🗆 140			ence 6 Other (S)	pecify)
	ding P h. After I tunera	ion:	27. Manner of Death 1 Natural 5 ☐ Pending		Day Year)	8b. Time o Injury	t 28	Bc. Injury Work	at ? ′es 2 □		28d. Describe h	ow injury occurred	
Division	or Attan	Certification:	2 Accident investigation of Could not determine the Accident not de	ot be 28e. Place of	Injury - At home etc. (Specify)	e, farm, st			95 Z		28f. Location (S City or Town	treet and Number or n, State)	Rural Route Number,
7	Hospital 4 hours Funeral ely tilled	edicai Ce	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the be xaminer: On the basis and manner	s of examination	edge, deat n and/or in	h occurred a vestigation,	at the tim in my op	e, date an inion, dea	d place, a	and due to the c ed at the time, d	ause(s) and manner late and place, and d	as stated. ue to the cause(s)
	To tha I within 2 To tha I complet	Med	29b. Signature and title of certifier	1 /			29c.	License	number		2	29d. Date signed (Mo	nth, Day, Year)
}	->-0	10	1 man	hu Do	Tune	N	1	UD:	2516	9		Dec 23/20	204
R	(10)		30. Name and address of person w	n B. Barnes,	of death (Item 2 M.D. 18	за) (Туре, 05 Вет					gton, D.C	20019	
	Sta Registi		31. Date filed (Month, Day, Year) DEC 2 9 20	2. Regi	strar's Signatur								

State of Maryland / Department of Health and Mental Hygien 42566 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Harry C. Wheeler 1851 M ber 20 20ch Decem /Medical 4c. County of Death 4a. Facility Mame (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Cheverk rince 6 coyes Hospital 6 copes | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | Washington, DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** XOM 20F 578-12-4278 84 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury grother traumatic event. The Medical Exprendent must be invitibled at once. 1 Yes 2 No Director D.C. N/A Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 42nd Street, N.E. 20019 17 #102 United States Completed by Funeral 12. Was Decedent Evergrup 26. Armed Forces? 1 XYes 2 No1 946 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Postal Clerk U.S. Postal Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hillary Wheeler Fannie Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Wheeler / daughter 1503 Gallatin Street, N.E., Washington, D.C. 20017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/27/04 Mt. Olivet Cemetery Washington, D.C. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Funeral Service Licensee 7400 Georgia Ave. N.W., Wash. D.C. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Anterposcherotic Hypertensive Henry Disease **Physician** /Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, physician Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ρ 3 ☐ Probably 4 ☐ Onknown 1 ☐ Yes 2 ☐ No been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has t autopsy 2 No 1 Yes To the Hospital or Attending Physician: uneral director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☐No 21 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No thours after death.

uneral Director: A sly filled in by the fu death. investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) HO035927 December 27 2006 101 30. Name and address of person oc completed cause of death (Item 23a) (Type, Print) Chererly, MAN LAND 3001 oi tal Sylveter SALVADOR 1005 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 27 2004

Se

			1 - For State Registrar	State of M	arylan		artmen rtificat				lental Hy	giene Reg. No	/ U	04	42	568
	Physici	an	1. Decedent's Name (First, Middle, La Callie M. Wood								2. Date of De Month Dec.	eath 25	y 20	Year 04		of Death
	/Medio		4a. Facility Name (If not institution, giv				4b. City,	Town, or	Location	of Death	4c. County of Death			O A		
1	Exami		Carroll Hospita	1 Center			We	stmi	nste	r			Ca	rro1		
	Funeral Director		212-24-5100	ex 7. Ag ☐ M 2 🔯 F	је (In yrs. 74	last birthday) , Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da May 13	th ay, Year 19	30	9. Birthp Cour Mar	yland	or Foreign
	ow ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							T-	l0d. Inside	City Limits
	e-fsh	ctor	Maryland Carrol	1		Keym	ar								1 ∐ Y∈	s 2⊠No
	with the	Dire	10e. Street and Number	Dood			10f. Zip	Code	2175	7		_	izen of W		•	
	ns 238	eral	5818 Keysville	12. Was Decedent	Ever in U	.S. 13.	Was Dece	dent of Hi	2175		ecify Yes or No		ed S		S can Indian,	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "netural", or Items 23a or 28e-f show other treumatic avent, Ite Medical Everthet must be ricitlised at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?		lf Yes, spec 1 ☐ Yes		Specify:		ecify Yes or No Rican, etc.)		Black	, White, Wh:	etc.	
2-00	72 hou	ted	15. Decedent's E.	ducation		16a. Dece	dent's Usua	al Occupa	ation	t of work	ina	16b. K	ind of Bus	siness/In	dustry	
21215-0036	vithin 7 ne. han "r	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of wo				ng .	Fa	ctor	ı, Mo	rlear	
d 2	Hygie ther t		12th 17. Father's Name (First, Middle, Last			I I	lachin	ie Op			(First, Middle				IKEL	
lan	id be lental ked o	To Be	, , ,	Charles Co	onawa	ιy					allie M			,		
Maryland	1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than ither treumatic avent, ILE Ms		19a. Informant's Name/Relationship (il Route Numb	er, City	or Town, S	State, Zip	Code)	
	1 and Health em 27 ther tr		Andrea L. Hajzer	Daught		5818 Place of Dispo	Keys		e Roa		Keymar,		217		own, State	
nor	eg = 5		20a. Method of Disposition 1 △Burial 2 □ Cremation 3 □		0	easant	natory or o	ther place								ل مدار،
Baltimore,	→ E # ÷		*4 □Donation 5 □ Other (Special 21. Signature of Funeral Service Lices	·	111						29, 20 cal Hom					
ñ	permi Depa Impo eny ii		> Xumb	011111		1	urrie 212 W	r-Qu J. 01	een l d Lil	berty	cal Hom 7 Road	e & Win	Crem	ator d, M	y, PA D 217	84
,	Physician /Medical Examiner	лег	23a. Part1. Enter the disease, or complete process of condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	a. META Due to (or as	STATI	uence of):	ON		2CIN			LIV	ER		Approxim Interval B Onset and	etween
,0928	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a conseq	uence of):										-
.O. Box 6	that the death certificated by the attending pludetached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknowh	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	ıl death 3□	Ectopic pr Other (sp						23d. Date Mon		ery Day	Year
rds, P.	quires that in signed to uld be det	by	Part II. Other significant conditions of	ontributing to death t	out not res	ulting in the u	nderlying c	ause give	n in Part I			obacco (Yes 2	_	bute to th	ne cause of pably 4	death?
I Records,		Completed					-	-	_		24a. Was auto perfo 1 \(\text{Yes}		de de	ere auto ior to co eath? Yes	psy finding mpletion of 2007No	s available cause of
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only					
of	Phys this ral di	7.	1 Yes 2 No 27. Manner of Death	1 ∐ Inpati 28a. Date of Inji	ıry	ER/Outpatier 28b. Time of		8c. Injury Work	4 🗆 NO		me 5 Resi				r)	
ion	Attending Ph ir death. ector: After th by the funeral	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	y Yeer)	Injury	М		? ∕es 2 🗍							
Division	al or Attend s after death il Director: /	Certification;	3 Suicide 6 Could not b 4 Homicide determined		jury - At h	ome, farm, str	eet, factory	, office			28f. Location (City or To	Street ar wn, State	d Numbe	r or Rura	l Route Nu	mber,
	To the Hospital or At within 24 hours after of Yo the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Pt	nysician: To the best niner: On the basis of and manner st	of examina	owledge, death	n occurred vestigation	at the tim , in my op	e, d <i>a</i> te an pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s date and	and man d place, a	ner as st	tated. the cause	(s)
	Tot You	Σ	29b. Signature and title of certifier		D		174	. License					-		Day, Year)	0
	New		Wf			- 02=1 77		UOS	6314	+		VEL E	MBE	K.	27"	2004
	V		PINDU GODECE	completed cause of	death (Iter		Print) OHNS	No	DRIV	5	FREI) (RI	CK	MD	217	02_
	Sta Registi		31. Date filed (Month, Day, Year) DEC 2	32. Regist		ature	ha									

			1 - For State Registrar	State of Mary		artment of H rtificate of		Re	g. No. UUL	42569
	Dhysioi	an	1. Decedent's Name (First, Middle, Last,)				2. Date of Death Month	Day Yea	3. Time of Death
	Physici /Medi			lliams				December	25, 200	4 1:45 P M
	Examir	ner	4a. Facility Name (If not institution, give				or Location of Deat	h	4c. County of D	
			Northampton Nur 5. Social Security Number 6. Se.	sing Home	yrs. last birthday)	Frede		8. Date of Birth	Freder	
	Funeral Director			M 2∏F 89	Yrs.	Months Days	Hours Min.		^{Year)} 1915 E	Birthplace (State or Foreign Country) ngland
	Maryland f show	tor	10a. State 10b. County MD Frederic		c. City, Town or Lo					10d. Inside City Limits 1 XYes 2 □ No
	3a or 28a	i Direc	10e. Street and Number 5781 Catoctin Vis	ta Drive		10f. Zip Code 21771		10	g. Citizen of What	Country?
036	n /2 nours aller death with the Maryland "naturel", or liems 23a or 28a-f show volcal Examiner munt be mylified al	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cubin		Specify Yes or No- to Rican, etc.)	Black, W	merican Indian, hite, etc. White
21215-0036	- 32	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo d)	rking	6b. Kind of Busine	ss/Industry
	Hygier Hygier ther ti		12 17. Father's Name (First, Middle, Last)		Hom	emaker	19 Mothor's No.	me (First, Middle, M	Own Home	
Maryland	should be tited within and Mental Hygiene. s marked other than umatic event, the Mental Hygiene.	To Be	James Mason				Mary El	len Blind	lston	
	and 2 sha saith and n 27 is m		19a. Informant's Name/Relationship (T) Jay M. Williams/			_		oral Route Number, Orive Mour		
Φ,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other than any injury or other treumatic event, the M. Once.		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Ob. Place of Dispo cemetery, crei Huntt Cr	natory or other pla		Date 2 28/2004	Oc. Location - City Waldorf,	
Balti	Departm Departm Importe any Inju		21. Signature of Funeral Service Licens	88		Name and Addre	ess of Facility Ro	bert E. F		eral Home 715
	Physician /Medical		23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	death. Do not ent					Approximate Interval Between Onset and Death 3 Jays
	Examiner	L		Due to (or as a co	ydratio	1				2 wks
	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	entia					many
8760,	cate be executed physicien and the burial-transit	edicai Exa	resulting in death) Last	Due to (or as a co	nsequence of):					
.O. Box 6	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22 No 9 □ Unknown	23c. If yes, outcome of portion in the control of portions and the control of portions and the control of the c	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of o	delivery Day Year
ds, P	uires mat signed b	þ	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	10	to the cause of death? Probably 4 □Unknown
m ;	ate h	Completed						24a. Was an autopsy perform	prior t death No 1 □ Y	autopsy findings available o completion of cause of ? es 2 \(\textstyle{\textstyle{1}}\) No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Ott		ath (Check only one		
ō	ਵ ≑ ਫ਼	ion: To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time of Injury	28c. Injur	4 Thursing F	dome 5 Resider		pecify)
=	or Atten	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)		103 2	28f. Location (Str. City or Town,		Rural Route Number,
	lo the hospitel within 24 hours a To the Funerel I completely filled	edicai C	29a. Certifying Phy (Check only one)	sician: To the best of m ner: On the basis of exa and manner stated.	y knowledge, death imination and/or in	n occurred at the time time time time occurred at the time occurred at t	me, date and place opinion, death occu	a, and due to the caurred at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	vithin To th compl	Me	29b. Signature and title of certifier	fril us	•	29c. Licens	53129		d. Date signed (Mo	1
			30. Name and address of person who co	ompleted cause of death		D				D 21703
R	Sta Regist	_	31. Date filed (Month, Day, Year) DEC 2 7 20							

DHMH 17 Rev 1/2001

ORIGINAL

		_	. 101	artment of Health and Mental Hy	giene Reg. N2 004 42570
	Physici	an	1. Decedent's Name (First, Middle, Last) Eloise Marie Weber	2. Date of De Month Dec.	
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	LXaiiiii	Ci	Anne Arundel Medical Center	Annapolis	Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 ☒ F 83 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Bi (Months Days Hours Min. / Month, D. Jun. 2	rth ay, Year) 9. Birthplace (State or Foreign Country)
	Director	-	220-01-2146	Jun. 2	19, 1921 MD
	Maryland	tor	10a. State 10b. County 10c. City, Town or Lo	seation Severna Park	10d. Inside City Limits 1 ☐ Yes 2 💆 No
	with the a or 28s	Direc	10e. Street and Number 310 Benfield Road	10f. Zip Code 21146	10g. Citizen of What Country? USA
36	d within 72 hours after death with the Maryland jiene. r than "natural", or Itame 23a or 28a-f show the Medical Evantral must be notified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 🖾 Married 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XNo Specify:	
21215-0036	within lene. than "	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired) Homemaker	16b. Kind of Business/Industry Home
Maryland 2	be filed tal Hyg id othe event,	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	e, Maiden Sumame)
Ž	s 1 and 2 should t f Health and Ment itam 27 is markac other traumatic e	2	William Nicholson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	Lillian Henry ng Address (Street and Number or Rural Route Numb	per, City or Town, State, Zip Code) 21146
	of Health ar itam 27 is other trau	ij		M Ritchie Hwy., PMB 150	
altimore,	Pages 1 and of He int: If item			position (Name of matory or other place) Ven Cemetery Dec. 27, 2004	20c. Location - City or Town, State Glen Burnie, MD
Balti	permit. Pages 1 Department of H Important: If its any injury or ot once.		21. Signal Fun ral Service Licensee	arranco & Sons, P.A. Sev 95 Gov. Ritchie Hwy, Sev	verna Park Funeral Home verna Park, MD 21146
			23a. Parf1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or respiratory a	arrest, Approximate Interval Between
4	Prysician	6 1	Immediate Cause (Final disease or condition resulting in death)	1 interction	Onset and Death
	/Medical Examiner		Due to (o as a consequence of):	1 interction	3
		ner	Sequentially list conditions, 1 my leading to immediate cause. Enter Undertying Cause (Disease or injury		
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9	rtificat ng phy i as the	Medicai	IF FEMALE:		
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rds, P.	es tha gned be de	þ	Part II. Other significant conditions contributing to death but not resulting in the u	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
I Records,	The ate h page	Completed		24a. Wa auto perf 1 □ Yes	
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only	
o		.: To	27. Manner of Death 28a. Date of Injury 28b. Time o		idence 6 Other (Specify) how injury occurred
ion	Attanding I r death. actor: After by the funer	ation	1- Natural 5 □ Pending (Month, Öay Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
Division	i di di	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury · At home, farm, str building, etc. (Specify)		(Street and Number or Rural Route Number, wn, State)
	Fur Ho	edicai (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.		
)	To the within 2 To the complet	M	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) Burge 10	20716
	Sta Regist		31. Date filed (Month, Day, Year) DEC 2 7 2004 32 Registrar's Signature	and .	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev Year **Physician** David Wilson, Jr. December 30, Elias 2004 8:20 AM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner Allegany County Nursing & Rehab Center Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/10/1916 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 1 M 2 □ F **Funeral** Months Deys Hours 214-07-5402 Yrs. Director Maryland Usuet Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiena. Important: If Hem 27 is marked other than "natural" or becase any injury or other traumatic averages. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No MD Funeral Director Allegany Cumberland 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 11801 Bedford Road, NE 21502 USA Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritel Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by White 3 Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify onfy highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Manager Petroleum 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be David Elias Wilson, Sr. May Urilla 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Route 2 Box 635, Ridgeley, WV C. David Wilson / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Locetion - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Rainsburg Meth. Prot. Un. Cem 1/4/05 Rainsburg, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Adams Family Funeral Home, P.A. 21. Signature of Puneral Service Licenses 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate therval Between Onset and Death **Physician** e. End Stage
Due to (or es o consequ /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

Within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be dateched for use as the burlet-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yee 2 No ģ 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? Completed completion of cause of death? +LIYes A□No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work? 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License numbe 29b. Signature and title of certifier 2-30-040 Jamen 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Barrera, Robustiano J. M.D., 500 Memorial Avenue, Cumberland, MD 21502

Registrar

State

31. Date filed (Month, Dey, Year)

DEC 3 0 2004

32. Registrer's Signature

· L · pole

		1 - For State Registrar	State of Maryland	/ Department of Certificate		Mental Hygier	/ III L	4257
Physici /Medi	cal	1. Decedent's Name (First, Middle, Las BASY BOY SHUAL	VOAI WY	dh Cin Tu		2. Date of Death Month December	Day Year 3. 29 2004	Time of Death
Examir Funeral Director	ner	4a. Facility Name (If not institution, give Greater Baltimore 5. Social Security Number 6. Se	Medical Cente	r st birthday) If Under 1 Y	TOWSON Towson Fear If Under 24 Hr ays Hours Mir	S. 8 Date of Birth	Baltimor B. Birthplace Country)	`C (State or Foreign
P .		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Location	//	DEC. 27, c	1007	nside City Limits
the Marylan r 28a-f show oxilities at	rector	Mary Land 10e. Street and Number		ALTIMORE 101. Zip Co	de	10g. (1	Yes 2 □ No
within 72 hours after death with the Maryland ene. than "natural, or Items 23e or 28e-f show the Madical Examination invalue incliffed at	Completed by Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give	13. Was Decedent	2/2 // of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American In Black, White, etc.	
within 72 hours ane. than "natural"	mpleted b	3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	16a. Decedent's Usual O (Give kind of work d life. DO NOT use n	ccupation one during most of we etired)	orking 16b.	Specify: ASIA Kind of Business/Industry	
should be filed and Mental Hygies marked other umatic event.	To Be Co	17. Father's Name (First, Middle, Last) AARON	W			ame (First, Middle, Maide		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Madical Examinar must be notified at once.		19a. Informant's Name/Relationship (7	Removal from State	C701 N, Came on the control of the c	WL6957	Date 200.	v or Town, State, Zip Code ZIZO S Location - City or Town, S	/
Physician //Medical Examiner prize pe executed the prize transit the prize transit pri	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) b. Severe Congecture to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	enital Heart	Disease		Onsi	et and Death
The law requires that the death certific tte has been signed by the atlending pl bage 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnanc 1 □Live birth 2 □Fetal di 4 □Pregnant at time of deal 9 □ Unknown	eath 3 Ectopic pregn			23d. Date of delivery Month Day	Year
quires that an signed b	þ	Part II. Other significant conditions co	ntributing to death but not resulti	ng in the underlying cause	given in Part I.		o use contribute to the cau 2 X No 3 ☐ Probably	
	Completed					24a. Was an autopsy performed?	24b. Were autopsy fir prior to completi death?	on of cause of
ding Physician: Th h. After this certificate funeral director, pag	To B	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending		8/Outpatient 3☐ DOA 8b. Time of Injury 28c.	Other	ath (Check only one) Home 5 ☐ Residence 28d. Describe how inj		
l or Atten after deatl Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At homo building, etc. (Specily)		1 ☐ Yes 2 ☐ No ice	28f. Location (Street a City or Town, Sta	and Number or Rural Rout te)	e Number,
To the Hospital within 24 hours a within 24 hours of To the Funeral completely filled	Medical (29a. Certifier Phy (Check only one)	sician: To the best of my knowle iner: On the basis of examination and manner stated.	edge, death occurred at the n and/or investigation, in r	e time, date and plac ny opinion, death occ	e, and due to the cause(urred at the time, date ar	s) and manner as stated. nd place, and due to the c	ause(s)
Tot	Z	29b. Signature and title of certifier	Thre.		5/876		ate signed (Month, Day,) 2/29/04 Md. 2/2	
Lit		30. Name and address of person who o	ompleted cause of death (Item 2	3a) (Type, Print)			1	

BOY SHUMNEA!

OM

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** N. Young Dec. 22nd. 2004 9:00₺. Bernard /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince Georges 1901 Bender Court Landover If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F Months Yrs. Director 1911 Clinton, 93 579_01 9582 Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits 28e-f ehow other treumatic event, the Medical Example in must be notified at MD Landover 1 X Yes 2 ☐ No Prince Georges Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 9 Items 23a 20785 1901 Bender Court United States death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other then "naturel", or Ites 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Midowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk State Department 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Young Eliza Fergunson 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 Ie n any injury or other treum 5999 Emerson St., #822 Bladensburg, Maryland 20710 Daughter Helen Blakeney 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1. Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) MD National Cemetery 12/29/2004 Laurel, Maryland 1. Signatur of Funeral Service 22. Name and Address of Facility John T. Rhines Funeral Home 3015 12th Street, NE Washington, DC 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician VPertensive Caldio Vas Culor disc disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) the Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ 1 ☐ Yes 2 ☐ No 1 Tes 2 X No Hospitel or Attending Physicien: 24 hours after death. 25. Was case referred to medical 26. Place of Death Check onl. one examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 2 Doc12803 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6005 Landover Rd. Chevery MA HASSAN. MOLAUT, MO 31. Date filed (Month, Day, Year) State DEC 2 9 2004 Registrar

			1 - For State Registrar	State of	Marylar		artmen <i>tificat</i> e			and M	ental Hyg	iene	004	42574
	Physici	an	Decedent's Name (First, Middle, Last) Decedent's Name (First, Middle, Last)			77					Date of Dea Month	th Day	Year	3. Time of Death 2:45 PM
	/Medic Examin		Rebecca 4a. Facility Name (If not institution, give:	street and nun	nber)	You		Town, or	Location of	of Death	Decembe		3, 2004 County of Deat	
	Cxamiii	er	Devlin Manor			Center	,,		umbeı		1			egany
	Funeral		Social Security Number 6. Sex	M 2∑F		. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birt	thplace (State or Foreign
	Director		213-18-2957 Usual Residence of Decedent	J W 243 F	88	Yrs.					12/06/1	916	Wes	t Virginia
	yland IOW		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						<u>.</u>	10d. Inside City Limits
	a-fsh	ctor	MD Allega:	ny		Cumb	erlan	d						1 X Yes 2 □ No
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23a or 28a-f show ent, Ita Marical Examiner must be notified at	Director	10e. Street and Number	A			10f. Zip	Code 215	0.2		1	-	en of What Co	ountry?
	eath v	Funerai	708 Mary land	12. Was Dece	dent Ever in L	IS 13 V	Vas Deced			nin? (Sne	cify Yes or No-	- ,	4. Race - Ame	nican Indian
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ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than. Instural; or Itams 23a or 28a-f show any injury or other traumatic event, Its Marical Ex illust orded be nutilised at Once.		20a. Method of Disposition			Place of Dispos cemetery, cren	sition (Nan	ne of	-				ation - City or	
altimore,	Page nent o int: If		1, DBurial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	emoval from S	State	11	Come	tors	,	1/2/:	2005	S	uffolk	, VA
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Box	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		rth 2 Feta	al death 3	Ectopic pr					23	3d. Date of deli Month	ivery Day Year
P.O.	the de / the a ched f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregna 9□ Unkno	ant at time of own	death 5∟	Other (sp	ecify)						
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rds	w require been sig should b										1 □ Ye	s 2 🗷	No 3□Pr	obably 4 Unknown
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Ë		rtific	3 Suicide 6 Could not be determined	28e. Place buildir	of Injury - At h ng, etc. <i>(Speci</i>	iome, farm, stre fy)	et, factory	, office		2	28f. Location (St City or Town		Number or Ru	iral Route Number,
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		×	29b. Signature and title of certifier	, 9	~		29c	License	number		2	9d. Date	signed (Month	n, Day, Year)
	2			len h				D1	7565			Dec	cember	23, 2004
	nes		30. Name and address of person who co		•		•	Nati	ona1	Hich	ıway, La	Va1≏	MD.	21502
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				epartment of l Certificate of			giene 0 L	42575
	Physici	ian	1. Decedent's Name <i>(First, Middle, Last)</i> Francis Roy Yonker			2. Date of Dea Month	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4h City Town	or Location of Death	Dec	27 2004 4c. County of Death	3:30 A ^M
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Dave		8. Date of Birth		place (State or Foreign ntry) aryland
	Director		220-34-1400	s.		July 3	30 1915 M	aryland
	yland now		10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
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	vith th	Director	10e. Street and Number 10300 Town Creek Rd NE	10f. Zip Code		1	0g. Citizen of What Cou	ntry?
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Items 23s or 28s-f show aumatic event, the Macheal Examinar must be notified at	Funerai	11. Marital Status 12. Was Decedent Ever in U.S.	2153	-	ocifu Vac or No.	USA 14. Race - Ameri	an Indian
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7	filed within Hygiene. Ither then "	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Farmer	30,		Agricultu	re
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Mar	d 2 sh th and 7 Is m traum						, City or Town, State, Zip	
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Ē	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artenent of Health and Mental Hygiene. ortents: if item 27 is marked other then. Instural; or Items 23a or 28a-f show injury or other traumatic event, itte Macified Examinat must be notified at injury or other traumatic event, itte Macified Examinat must be notified at 9.		1 □ Qurial 2 □ Cremation 3 □ Removal from State Hillc:	crematory or other pla cest Mem	Pk. 12/2	9/04	Cumberlan	d, MD
Dallimor	permit. Pages 1 and 2 Department of Health s Important: If item 27 li any injury or other tra		21. Signature of Funeral Service Licensee .	22. Name and Addre	IIu	fer Fu	neral Ser	vice PA
_	205 g g		Souds Stole	1302 Nat	ional Hw	у., La	vale, MD	21502
			23a. Part1. Enter the disense or complications that cause the death. Do no shock, or heart failured ist only one cause on each line. Immediate Cause (Final	enter the mode of dyi	11	90	est,	Approximate Interval Between Onset and Death
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0	The law requires that the death certificate attending phys page 2 should be detached for use as the	hysician/Medical	IF FEMALE:					
200	ath ce	ian/l	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 DEctopic pregnanc	;y		23d. Date of delive Month	nry Day Year
j	the de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 ☐ Unknown	5 ☐ Other (specify) _				
Ĺ	ires that the death certific signed by the attending p d be detached for use as i	by Pt	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause gr	ven in Part I.	23e. Did tob	pacco use contribute to the	e cause of death?
Š	w require					1 □ Ye	es 2 □ No 3 □ Prob	ably
ב ב	e 2 sh	Completed				24a. Was a autops	n 24b. Were auto	osy findings available inpletion of cause of
ם	ician: The lav certificate has rector, page 2						1 ☐ Yes	200
=	/sicial s certi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 1 1 ☐ Inpatient 1 ☐ Inpatient 1 ☐ EP/Outp:	atient 3 DOA Oth	26. Place of Death her: 4 \(\sum \) Nursing Hon		el Other (Specifi	a a
5	ng Phy ter thi	n: T	27. Manner of Death 1. Matural 5 Pending 28a. Date of Injury (Month, Day Year) Inju	ne of 28c. Injur	al-train and a second		w injury occurred	7
2	tendir leath. lor: Ai the fu	catic	2 Accident investigation	M 1	Yes 2□No			
5	I or At after of Direct I in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	2	8f. Location (St. City or Town	reet and Number or Rura 1, State)	l Route Number,
	To the Hospitel or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 12 Certifying Physician: To the best of my knowledge, of	leath occurred at the ti	me, date and place, a	nd due to the ca	luse(s) and manner as st	ated.
	the He iin 24 the Fu npletel	fedical	(Check only 2 Medical Examiner: On the basis of examination and/cone) and manner stated.					
	7	Σ	29b. Signature and title of certifier	29c. Licens			9d. Date signed (Month,	
	6		30. Name and address of person who completed cause of death (Item 23a) (Ty	rpe, Print)	7	0	12/28/	UT
1	nfs	7	Hay Ahmod MD 625	Kent 1	IVE, 10	Z Cu	12/281 mberland	MD
	Sta 'Registr		31. Date filed (Month, bay, Year) DEC 2 8 2004 32. Registrar's Signature	4 hours	11			/
				- John Color				

			. For			epartment of Hea				
			1 - State Registrar			Certificate of De	ath	Reg.		42576
	Physici	an	1. Decedent's Name (First, Middle, La	st)		ZENT		ate of Death lonth	Day Year	3. Time of Death
	/Medic	al	KOBERT 4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or Loc	1/10	com les	4c. County of De	04 23:20 M
	Examin	er	The Tohnis Hon	Kins Hosi	ital	BAHIMADE	1 1	-	40. County of De	au
	Funeral		5. Social Security Number 6. S	Sex 7. Age	In yrs. last birt	hday) If Under 1 Year If I		ate of Birth fonth, Day, Ye	9. Bi	irthplace (State or Foreign Country)
	Director		216-38-3827 Usual Residence of Decedent	1 M 2 □ F 6:	3`	rs.				Jaryland
	yland now		10a. State 10b. County		I Oc. City, Town	or Location				10d. Inside City Limits
	e Mar	ctor	Maryland Carrol	.1	Fi	nksburg				1 ☐ Yes 2 🔀 No
	with th	Director	10e. Street and Number			10f. Žip Code		10g.	Citizen of What C	Country?
	eath v	Funeral	3370 Old Gamber	Rd.	er in U.S.	21048	nic Origin? (Specify V	es or No-	USA 14. Race - Am	nerican Indian
ور	or Item		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give		13. Was Decedent of Hispar If Yes, specify Cuban, M		, etc.)	Black, Wh	
2-0036	should be tiled within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", in items 12a or 28a-f show matic event, if the Madical Extr. it is real the multified at	d by	3 Widowed 4 Divorced	Year or Dates:		77	oecify:		Specify:	White
<u>7</u>	n 72 h	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	g most of working		. Kind of Busines:	s/Industry al Custom
212	iene. rthan	ошр	Elementary/Secondary (0-12)	College (1-4or 5+)		Builder			omes	ar Custom
9	be tiled tal Hygir d other event, II	Bec	17. Father's Name (First, Middle, Last)		18.	Mother's Name (Firs	t, Middle, Maid	den Surname)	
<u>Xa</u>	should band Ments in marked	To	Robert Eugene Ze				Helen Go	·		
Maryland 2121	2 E 8 2		19a, Informant's Name/Relationship (Туре, Print)		Mailing Address (Street and I				
	Health tem 27 tem 27		Judy Zentz Wi 20a. Method of Disposition	.fe		70 Old Gamber Disposition (Name of commatory or other place)	Date	sburg,	MD 210 Location - City o	
Ë	permit. Pages Department of I Important: If it eny injury or o		1 Donation 5 ☐ Other (Special Control of Co	Removal from State (y)		een Memorial	12/28/0	A Fi	nkahuma	Maryland
Baltimore,	permit. Departm Importa eny inju		21. Signature of Funeral Service Lice	see	LIVELGE	22. Name and Address of	FacilitPritts	Funera	1 Home &	Chapel, PA
80	g ⊒ ≣ 29		23a. Part1. Enter the disease, or com	=		412 Washingto	on Rd. Wes	tminst		21048 Approximate
	Iticate be executed Medical Examiner and supplies the purial-transit is the burial-transit.	Examiner	shock, or Neart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Acvte Due to (or as a c b. Due to (or as a c c.	consequence c	f):	mia			Interval Between Onset and Death One week
/60,	be exectan a		resulting in death) cast	Due to (or as a	consequence o	f):				
687	ficate physi s the t	edlcal		_ d.						
O. Box	The law requires that the death certifica tle has been signed by the attending ph age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	elivery Day Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions of	contributing to death but	not resulting in	the underlying cause given in	Part I. 2	3e. Did tobacc		robably 4 Denknown
I Records,		Completed						4a. Was an autopsy performed ☐ Yes 2 ☐	? prior to death?	utopsy findings available completion of cause of
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	Manifeli	-		Place of Death (Che	ck only one)		-) 2
<u>o</u>	Physic rthis raldir	T.	1 Yes 2 No 27. Manner of Death	Hospital: 1 Impatient 28a. Date of Injury	2 🗆 ER/Out 28b. T		Nursing Home 5	Residence		ecify)
	Attending Physician: r death. ector: After this certific by the funeral director,	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day)	/ear) In	jury Work? M 1 ☐ Yes		CSCIDE NOW II	july occurred	
Division	ital or Attendi us after death. ral Director: A lled in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined		- At home, far (Specify)	m, street, factory, office		cation (Street ity or Town, St		lural Route Number,
	pital o		29a. Certifier 1 Certifying Pt	uveicien. To the best of	my knowledge	death occurred at the time, da	ata and place, and di			4
	ne Hospital 24 hours te Funeral detely filled	Medical	(Check only 2 Medical Examone)	niner: On the basis of each of manner state	kamination and	Vor investigation, in my opinior	n, death occurred at t	he time, date a	and place, and du	e to the cause(s)
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	Me	29b. Signature and title of certifier	//		29c. License nun		1	Date signed (Mon	
	WJL		felly By	alt N	1. P.	RES	-000	De	cember	- 23, 2004
	20		30. Name and address of person who	completed cause of dea	th (Item 23a) (RES Type, Print) Ospital; 600 N	1. 10. 10. 1	·/	0.11.	and an alam
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	000 V	1. Wolfesi	reet,	Baltima	DIE MES 21287
	Registr		DEC 2		ene l	Locale 1				

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Arnold Allen 1510 December 23 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** The University of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, 1963)

Months Days Hours Min. (Month Day, 1963) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 unk Funeral Months 1**∑**M 2□F Yrs. Director 214-92-6153 Usual Residence of Decedent death with the Maryland 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits or 28a-f show other traumatic event, If a Medical Exercitive must be nutified at MD Anne Arundel Jessup 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20794 Box 535 Md House of Corrections USA "natural", or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If liem 21 is marked other than "natural", or lien any injury or other traumatic event 1 Never Married 2 Married ☐Yes 2 ☐ No unk Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: black If Yes, Give Year or Dates: 2 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Rosetta Barley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **UMMS** 22 S. Greene Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State '4 ☐ Donation 5 🕅 Other (Specify) in state Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pancreatitis /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. should be detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct 4 Momicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number amy Mc Closhy , mo 15951 23, 2004 December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, maryland 21201 South Greene Street 22 Amy McClosky 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Amend Items 24a, 27, 29a per Dr. C839 / dhb01 / 1005 Registrar AMEND ITEM #2 PER DVR C839 1/10/05 JH Reg. No. 2. Date of Death Month AUSTIA De Center 26 **Physician** M253 GEORGE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL NO LITTURE ST RANDAUS TOWN SACTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min 12M 2 F 225-38-3886 Director Usual Residence of Decedent 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be multied at 1₽Yes 2□No Director 10e. Street and Number 10g. Citizen of What Country? ö USA or Itams 23a Funeral 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ If Yes, Give Year or Dates:US AAMY Specify: 3 Widowed 4 Divorced BLACK natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) then College (1-4or 5+) marked other 17. Father's Name (First, Middle, Last) h and Mental F Be AUS TIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 l 20c. Location - City 20a. Method of Disposition 20b. Place of Disposition (Name of or Town, State Department of Important: If it any injury or conce. ō 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Ineval Service Licensee 22. Name and Address of Facility prythe disease, or complications that caused the math. Do not enter the mode of dying, such as cardiac or respiratory arrest, feart favure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Gause (Final Attoroschofic DISEASE CONONAM HEART **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown sate has been signed I page 2 should be det Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? þ Records. Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown The law 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No Vital 1 Yes Hospital or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No 2 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🔲 Inpatient ō 27. Manner of Ceath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D 00 56 430

Registrar

market

Rodney Biglow, 5401 Old Court Road, Randallstown, MD 21133

32. Registrar's Signature

30. Name and addrest of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Marin Day, Year) 2005

			For State Registrar	State o	f Marylan		artment rtificate			and M	F	Reg. No	4004	42	2579
	Physicia /Medic		1. Decedent's Name (First, Middle Mabelle Brow								2. Date of Dea Month Decembe	r 17	2004	11:	of Death
	Examin		4a. Facility Name (If not institution 513 Aldergat	-	mber)		l	omor	ıs				County of Dee	ert	
	Funeral Director		5. Social Security Number 579–18–5405	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 84	/ast birthday) Yrs.	If Under 1 Months	Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Day Jan 15	h y, Year) , 19	9. Bin Co Wash	hplace (State ountry) ingto:	e o <i>r Foreign</i> n DC
	Aaryland f show	ō	Usuel Residence of Decedent 10a. State 10b. County MD Cal	vert	10c. Cit	ty, Town or Lo	ocation Omons								City Limits
	with the Page or 28a-	Director	10e. Street and Number 513 Aldergate	e Court			10f. Zip 0		0688			10g. Cit	izen of What Co	L ountry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic svent, the Medical Examiner must be multiled at ODGs.	by Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Dec	2X No ve	1	Was Decede If Yes, specif		spanic Origin, Mexican	gin? (Spi , Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify: Wh	e, etc.	,
Maryland 21215-0036	within 72 houene. ene. then "nature	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t's Education at grade completed)		(Give	dent's Usual kind of work DO NOT use	done d retired)	ition uring most	t of work	ing		ind of Business state d		
yland 2	should be filed ind Mental Hygi s marked other umatic svent,	To Be Co	17. Father's Name (First, Middle, Charles Wende		er						e (First, Middle, 19 Vaux			•	
	ss f and 2 sho of Health and item 27 Is my r other traums		19a. Informant's Name/Relations William Brower 20a. Method of Disposition	/spouse		1-	Alder	gate	e Cou	rt S	olomons Olomons	, MI			
Baltimore,	permit. Pages Department of I Important: If its any Injury or of once.		1 Burial 2 Cremation 4 Donation 5 Other (S) 21. Signature of Euneral Service Ronal Li	pecify)		r Si	2. Name and tate A				1 ^{655 W} .	Bal	timore	Stree	t
	Physician /Medical Examiner	Examiner	23a. Part Enter the disease or shock, a heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due to	caused the deal each line. (or as a consector of the cons	th. Do not entraction of the property of the p			, such as	cardiac o		rest,		Approxin Interval I Onset ar	nate Between
Box 68760,	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	Physician/Medical Exa	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	(or as a consection of pregnition of pregnition at time of consection o	ancy	□Ectopic pre				DŽ		23d. Date of de Month	livery Day	Year
s, P.O.	es that the d gned by the be detached	by Physic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant condition	9□ Unkr	nown				n in Part I.	,			use contribute to		
Vital Records,	The law requires that the death certifica ate has been signed by the attending phyage 2 should be detached for use as it	Completed									24a. Was	rmed?	24b. Were as prior to death?	utopsy findin- completion o	as available
Vita	Physician: r this certificanal director,	o Be (25. Was case referred to medical examiner?	Hospital		100.0	-5-0	Othe			(Check only o				
Division of	Jing After fune	H- 1	1 Yes 2 No 27. Manner of Death 1. Natural 5 Pendin 2 Accident investig	28a. Date (Mor	Inpatient 2 of Injury oth, Day Year)	28b. Time o Injury		Bc. Injury Work	4 🗀 140		me 5 Resid 28d. Describe h			спу)	
Divisi	i i i i i	Certification;	3 Suicide 6 Could determ	ined 288. Plac	e of Injury - At h ling, etc. (Speci	ome, farm, st fy)	reet, factory,	office			28f. Location (5 City or Тои			ural Route N	umber,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	edical	(Check only 2 Medical one)				vestigation,	in my op	oinion, dea		ed at the time,	date and	place, and due	to the caus	
	With To	M	29b. Signature and title of certifie				29c.	License) U =	number	0		12/-	te signed (Mont	n, Day, Yeai	7)
			30, Name and address of person	who completed cau	se ordeath (Ite	m 23a) (Type,	Print)	Pus	sley	h	12	06	57		
Ž.	Sta Registi		31. Dane filed (Month, Day, Year) JAN 0 7 201		Registrar's Sign	ature)	,						7		

			1 - For Stete Registrar	State of M	laryland / Depa <i>Ce</i>	artment of Heartificate of De		ental Hygier Reg. r	/ 11 11 /1	42580
	Physici	an	Decedent's Name (First, Middle		D			2. Date of Death Month December	29 2004 Par	3. Time of Death
	/Media	cal	Patricia 4a. Facility Name (If not institution		Bernstein	4b. City, Town, or Loc			4c. County of Death	9:00 a M
	Examir	ier	Genesis Elde	. •	•	Annapolis	oation of Beauti		Anne Aru	nde1
	Funeral Director		5. Social Security Number 216-36-3116	6. Sex 1 ☐ M 2 ☑ F	ge (In yrs. last birthday) 64 Yrs.		lours Min.	8. Date of Birth (Month, Day, Yea Aug. 6, 1	9. Births 940 Mary	place (State or Foreign ntry) 1and
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation			1	0d. Inside City Limits
	e-fsh	ctor	MD Anne	Arunde1	Annapo	lis				1 ☐ Yes 2 ☐ No
	vith the	Funeral Director	10e. Street and Number	•		10f. Zip Code		10g. (Citizen of What Cour	ntry?
	eath v	eral	130 Hearne Roa	12. Was Deceden	t Ever in U.S. 13	21403	nic Origin? (Spec	ify Yes or No-	USA 14. Race - Americ	ean Indian
Maryland 21215-0036	d within 72 hours after death with the Maryland Jiene r than "natural", or Items 23a or 28e-f show It e Madical Examirer must be notified at	by	1 ☐ Never Married 2 ☐ Marriad 3 ☐ Widowed 4 🛣 Divorced	Armed Forces	7N O	Was Decedent of Hispa If Yes, specify Cuban, M 1 ☐ Yes ②XXNo S	Mexican, Puerto R	ican, etc.)	Black, White,	
2-0	72 ho	Completed		t's Education st grade completed)	(Give	dent's Usual Occupation kind of work done durin		16b.	Kind of Business/In	dustry
121	within iene. than '	dmo	Elementary/Secondary (0-12)	College (1-4o	5+) life.	DO NOT use retired)			.1h	O -
d 2	Hygi Hygi ther	Be Co	17. Father's Name (First, Middle,	Last)		erator 18.	. Mother's Name	(First, Middle, Maid	elephone	UO.
/lan		To B	Bernard Richa	rd Murray		(Olive Pau	ıline Col	lison	
Jan	2 sho and I Is me		19a. Informant's Name/Relations			ng Address (Street and				Code)
	1 and Health em 27		Tamara Hooper 20a. Method of Disposition	(Daughter)	20b. Place of Dispo	Hilltop Lar	ne, Annar		21403 Location - City or To	own State
OE	Pages ent of nt: If it		1 Burial 2 Cremation 4 Donation 5 Other (S			natory or other place)	12/30/		ltimore, 1	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other traumatic enone.		21. Signature of Funeral Service			Name and Address of Hardesty	f Facility Funeral 1	Home, P.A	•	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	ed the death. Do not ent	12 Ridge1s er the mode of dying, si			1s, MD 21	Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition resulting in death)	a	0	you, do	mer			Onset and Death
	/Medical Examiner		rooming ar down,	Due to (or a	s a consequence of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a consequence of):					
	ecuted and -transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	cate be executed physician and the burial-transit	al E	, and a second property of the second propert	Due to (or a	s a consequence of):					
687	ificate g phys as the	edical		d						
O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Wo 9 ☐ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ny Day Year
ď.	res that the d signed by the be detached		Part II. Other significant condition	ons contributing to death	but not resulting in the u	nderlying cause given in	Part I.	23e. Did tobacco	use contribute to th	e cause of death?
rds	= " 0	ed by						1 🗆 Yes	2 □ // 3 □ Prob	ably 4 🗆 Unknown
Records,	e taw has b	ompleted						24a. Was an autopsy performed?	prior to cor death?	osy findings available npletion of cause of
Vital	sicien: Th certificate irector, pag	Bec	25. Was case referred to medical examiner?			26	. Place of Death	1 □ Yes 2 □ N Check only one	10 103	20140
of V	× 5 5 5	은	1 ☐ Yes 2 ☐ Male	Hospital: 1 Inpat					6 ☐ Other (Specify)
	ding I h. After funer	tion	27. Manner of Death 1 Accident 2 Accident		ay Year) 28b. Time of Injury	Work?	2 No	d. Describe how inj	ury occurred	
Division	I or Attending after death. Director: After I in by the fune	ertification;	3 Suicide 6 Could determ	not be 28e. Place of Ir	njury - At home, farm, str etc. (Specify)			If. Location (Street a City or Town, Sta	and Number or Rura te)	Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)	g Physicien: To the bes Exeminer: On the basis and manner s	of examination and/or in	n occurred at the time, divestigation, in my opinio	date and place, and on, death occurred	d due to the cause(I at the time, date a	s) and manner as st nd place, and due to	ated. the cause(s)
	To the P within 24 To the F complete	Me	29b. Signature and title of Certifier			29c. License nu	mber	29d. D	ate signed (Month, I	Day, Year)
)	10		> 13 1/2 N	Curu		0 5	16260	/	7138/1	204
	Ψ		30. Name and address of person		death (Item 23a) (Type,	nh Dri	ve U	astr. MI	16/5 (g
4	Sta Registr		31. Date filed (Manth, Day, Year)	005 32. Regist	rar's Signature	Y 9				

	MAN		1- For Unpend Item 2	State of Maryland / Dep. 3a,pt.11,27,28a-f.	artment of Health and l Der me 6839 1-25-0 rtificate of Death	Mental Hygie 5 tas	ne2004	4258
	Physic	ian	Decedent's Name (First, Middle, Last, Dougland, Double, Last,			2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	Paul Bato			December	24, 2004	0950 A M
	Exami	ner	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	
			8013 Mandan Toad 5. Social Security Number 6. Security Number		Greenbelt If Under 1 Year If Under 24 Hrs.	O Date of Birth	Prince Ge	
122	Funeral Director		180-48-8955	7. Age (In yrs. last birthday) 48 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye SEP 3, 1		place (State or Foreign ntry) 71and
4 -	ryland how		10a. State 10b. County	10c. City, Town or Lo			1	10d. Inside City Limits
	e Ma Sa-fa	cto	Maryland Anne Ar	rundel Gar	nbrills			1 ☐ Yes 2 XNo
	or 28	Dire	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cour	ntry?
	s 23s	Ta .	999 Jason Court		21054		USA	
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is markad othar than "natural", or Itams 23a or 28a-f ahow othar traumatic ayant, the Medical Examinaria was be multiled at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
5-0	72 ho natur	Completed	15. Decedent's Edu (Specify only highest grad		dent's Usual Occupation	ring 16t	b. Kind of Business/Ind	dustry
21	within ene. than "i	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done during most of work DO NOT use retired)	ung		
	lled v lygie har ti nt. In		17. Father's Name (First, Middle, Last)	4 Sa	les		Retail	
anc	ould be filed Mental Hygi arkad othar atic avant, I	Be	Joseph Batchison			e (First, Middle, Mai		
Maryland	thould d Men marka matic	2	19a. Informant's Name/Relationship (Ty		ng Address (Street and Number or Rui	et Hutchi		
Z	and 2 sho salth and I n 27 Is me	-	Joseph Batchison/b					Code)
ē,	f Health item 27 other tre		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	ills, MD :	∠1∪⊃4 :. Location - City or To	own, State
9	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)		matory or other place) ematory, Inc. 01/1	0/05	Baltimore,	MD
Baltimore,	permit. Pages 1 and 1 Department of Health Important: If item 27 any injury or othar tr once.	1	21. Signature of Funeral Service Licano		Name and Address of Facility LY			TID
m	88 = 8		Thomas Gre	gor 2	99 Frederick Road	or maryiai Baltimoi	nd, Inc. re MD 212	28
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not ent to cause on each line. Narcotic And Alcoh Due to (or as a consequence of):		or respiratory arrest,		Approximate Interval Between Onset and Death
	ם ב	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
9	rtifica ng ph as th	Medi			7000			
.O. Box	at the death certific by the attending p tached for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of deliver Month	ry Day Year
<u>α</u>	s that ned b e deta	by Pr	Part II. Other significant conditions con	tributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
Records,	quires an sign uld be		Carcinoma Of Neck			1 ☐ Yes	2 No 3 Proba	ably 4 Unknown
S	law requas been 2 shoul	Completed				24a. Was an	24b. Were autop	osy findings available
R	The I	mo				autopsy performed	prior to com death?	npletion of cause of
Vital	ian: ntifica ctor, j	Bec	25. Was case referred to medical		26. Place of Death	1 Yes 2 (Check only one)	No 1 Yes	2 1 100
of V	Physician: this certific al director,	10	examiner? 1 XYes 2 No	ospital: 1 Inpatient 2 ER/Outpatien	t 3 DOA Other: 4 Nursing Ho	me 5 Residence	6 € Other (Specify,	At scene
		on:	27. Manner of Death 1 □Natural 5 □ Pending	Found 28a. Date of Injury (Mooth, Day Year) Found 28b. Time of Found		28d. Describe how in		nk
Division	tor: the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	12-24-2004 9:30	M 1 ☐ Yes 2 X No			
Ö	Dirac in t	ertif	4 Homicide determined	28e. Place of Injury - At home, farm, streed building, etc. (Specify) Scene	eet, factory, office	28f. Location (Street City or Town, St	and Number of Rural ate) 8013 Man	Route Number, dan Rd.#T2
	a Hospital or Al 24 hours after o a Funaral Dirac etely filled in by		29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, death		reembert,	rid	
	a Ho	edical	(Check only 2 Medical Examin one)	er: On the basis of examination and/or inv	restigation, in my opinion, death occurr	ed at the time, date a	and manner as sta and place, and due to	the cause(s)
	To the Hospital within 24 hours a To the Funeral completely filled	Me	29b. Signature and title of certifier	111	29c. License number	29d. [Date signed (Month, D	ay, Year)
	-		Mayhour 1	me Mull IM	O.C.M.E.	Dec	cember 25,	2004
			30. Name and address of person who con	mpleted cause of death (Item 23a) (Type, F	Print)		Jemoci 20,	2004
			MARINAMO		Penn Street, Balt	imore, Ma	aryland 21	201
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrate Signature	South!			

			State of Maryland / Department of Health and I State Registrer State of Maryland / Department of Health and I Certificate of Death		giene leg. NG 0 0 1	+ 42582
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day_ Ye	3. Time of Death
	/Media		Mary Elizabeth Brown	Decemb		
	Examir	ier	4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death A I Time R		4c. County of D	eatn
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		9.	Birthplace (State or Foreign
	Director		218-48-3693 1 M 21 F 60 Yrs. Months Days Hours Min.	9-25-		Country) Md
!	pur *		Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10c. City, Town or Location			10d. Inside City Limits
7	the Marylar 28a-f show	ō	Ralto			1 XYes 2 No
ARI	the h	rect	Md N/A But to 10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
K	th with 23s or	ai D	4002 Ayrdale Avenue 21215		USA	
3	after death w	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race · A Black, V	merican Indian, Vhite, etc.
	IL Z IZ ID-UUSO filed within 72 hours after death with the Maryland Hyglene. thar than "natural", or Items 23a or 28a-f show ant, the Modical Extentional be notified at	oy Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 3(XXNo If Yes, Give 1 ☐ Yes 2(XXNo Specify: Year or Dates:		Specify:	Black
Swo	Z I Z I 3-0030 of within 72 hours aft gliene. ar than "natural; or the Wedled Extent	Completed by	15. Decedent's Education 16a Decedent's Usual Occupation	rkin n	16b. Kind of Busine	ess/Industry
3	Ithin 7	npie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 th conditions and the condition of the condition o		Western	Electric
	d C I C	S	12th grade 13 College		Maiden Sumame)	
à	re, Maryland , s 1 and 2 should be file. Health and Mental Hygitam 27 is marked othat other traumatic avant.	Be c		Cottrell		
	Marylanc 2 should be f 3 and Mental by the marked of raumatic ava	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Richard N			e, Zip Code)
	e, Mis 1 and 2 Health a am 27 ls		Michele Williams - Daughter 3619 Lochern Drive B	alto, Md	21207	
	attimore, mit. Pages 1 a partment of Her portant: If item y injury or othe		20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 □ Removal from State	Date	20c. Location - City	or Town, State
	FIMOR Pages tment of tant: If its		`4 Donation 5 Other (Specify) Garrison Forest Vet 1-10	The second secon		ills, Md
	Battlmort permit. Pages Department of b Important: If its any injury or of once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash	March F/		21215
			23a. Parit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiar shock, or headfailure. List only one cause on each line.			Approximate Interval Between
	Pnysician		Immediate Cause (Final	2 ctio	α	Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or s a consequence of):		-	
	Examiner	L	Sequentially list conditions, b			
	ed sit	ine	Sequentially list conditions, if any leading to inmodest cause. Enter Underlying Cause (Disease or injury			
	be executed sician and burial-transit	Examine	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
	BOX 68 / 6U, sath certificate be evattending physician for use as the buria		d			
	od rtificat ng phy as th	Medi	IE SERVALE.			
	BOX DB Beath certifica attending ph	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of Month	delivery Day Year
	hat the dea of by the ar	ysici	1 Yes 2 No 9 Unknown 5 Other (specify)			
	IS, F.C.		Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23a. Did to	bacco use contribut	e to the cause of death?
	rds quires n sign	ed by	ty per lension	1 🗆 Y	′es 2 □ No 3 □	Probably 4 Unknown
	aw require ts been sig	Completed	HypercholesTerolemiA	24a. Was a	an 24b. Wer	autopsy findings available to completion of cause of
	The law ate has page 2 s	Com		perfor	mod⊌ l deat	h? Yes 2 No
	cian: ertifica	Be (examiner?	ath (Check only or	пе)	
,	Of Physic this c	5 T	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H		lence 6 Other (Specify)
	ding ding h. After funer	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident State of Injury 28b. Time of Injury 28b. Time of Injury 32b. Time of Injur	200. 0030100 11	ow injury cocurred	
	UNVISION OT VITAI HECOTOS, I or Attanding Physician: The law requires that death. Diractor: After this certificate has been signed in by the funeral director, page 2 should be	ifica	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 5 ☐ Could not be building, etc. (Specify)	281. Location (S City or Tow	Street and Number o	r Rural Route Number,
	Ltal or s after s after at Direct Bed in I	Certification;	# Hollicide Building, etc. (<i>Specify</i>)	Ony or Ton		
	LIVISION Of VITal HECONDS, P.O. BOX 68/6U, To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occ			
	o tha ithin 2 o tha	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (M	
	F 3 F 8	0/	med (physician Doosyss 8	- 7	Decemb	eR 31,2004
	10100		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			11.00000
	lo		Frenzell Buck JR, MOZYOI W. Belvedere F	tue BA	HMORE	er 31,2004 MD 21215
	:	ate	31. Date liled (Month, Day, Year) A2. Registrar's Signature			
	Regist	ıar	OMPI I W 2003 ARMEN AS ASSESSED			

Please Type or Print in	Black Indelible Ink.	Ensure All Copies	Are Legible

			For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artment rtificate					gien Reg. N	/ 11 11		42583
İ	Physici		1. Decedent's Name (First, Middle, Donald A. Brown	•							2. Date of Dea Month DECEMBE	ath	Ĭ, 20Ŏ	ar 4	3. Time of Death 9:45 A _M
ì	/Medic Examin		4a. Fecility Name (If not institution, VA MARYLAND HEA	•	*		4b. City,			of Death	T	4	c. County of D		1
	Funeral Director		080-07-8081	6. Sex 1□M 2□F	7. Age (In yrs	s. <i>last birthday)</i> Yrs.	If Under Months	1 Year Days	If Unde Hours	Min.	8. Date of Birt Sept.	h 1.2°ear	^{9.} 1920 1	Birthp Coun New	lace (State or Foreign try) York
	ne Maryland 8a-f show diffied at	Director	Usual Residence of Decedent 10a. State 10b. County Md. Harfo	ord	10c. C	City, Town or Lo	Edge			_					0d. Inside City Limits 1 ☐ Yes 2 No
	ath with the 23a or 2		10e. Street and Number 301 Broadneck (Crossing				1040					U.S.A		try?
036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23s or 28s-1 show marked other than "natural", or Items 23s or 28s-1 show marked other than "walfeal Exame ar mast be rudified at	by Funerai	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed F	2 □ No ive		Was Deced f Yes, spec 1 Yes 2		spanic Oi n, Mexica Specify		acify Yes or No- Rican, etc.)	•	14. Race - A Black, V Specify:		etc.
21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	grade completed) (1-4or 5+)		dent's Usua kind of wor DO NOT us chani	rk done d e retired,	ition fu <i>ring</i> mo	st of worki	ing		Kind of Busin		,
and 2		Be	7 years 17. Father's Name (First, Middle, L	ast)	,	ille ille	Chani				(First, Middle,			all	ecca
Maryland	0 8 8	2	George Brown 19a. Informant's Name/Relationsh Foster Brown/so						ind Numb	er or Rura	A Route NumberrettsV:	_			
altimore, I			20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp	3 □Removal from	State	Place of Dispo cemetery, cren	sition (Nam natory or ot	ne of ther place	a)	[Date	20c. l	ocation - City	y or To	wn, State
Baltir	permit. Page Department of Importent: If any injury or once.		21. Signature of Fundral Service t		2 100.	22	Name and Schim	d Addres unek	s of Facil	eral	Home of	f Be	el Air	, I	nc.
, i	Pnysician /Medical		23a. Parf. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on	caused the deseach line. LYMPHO	ath. Do not ent							ri, riu		Approximate Interval Between Onset and Death
8/60, 1	cate be executed by sician and burial-transit in the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Character in the condition of the co	b. — Due to	o (or as a conse	equence of):									
O. Box 6	at the death certific by the attending parached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregi birth 2 Te gnant at time of nown	tal death 3	Ectopic pre						23d. Date of Month		ry Day Year
rds, P	law requires that as been signed b 2 should be deta	by	Part II. Other significant condition URINARY RETET		death but not re	esulting in the u	nderlying ca	ause give	in in Part	l.			use contribut		e cause of death?
I Kecords,	The ate h page	Completed	BENIGN PROSTA	TIC HYPE	RTROPHY	Y		-			24a. Was autop perfor	sv	prior	to con	osy findings available npletion of cause of 2 No
Division of Vital	Attending Phy er death. rector: After this by the funeral d	ertification; To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending investig: 2 Accident investig: 3 Suicide 6 Could no determine	28a. Date (Mo	of Injury oth, Day Year)	home, farm, str	M 2	8c. Injury Work 1 🗆 Y	or: 4[X]N at	ursing Ho	n (Check only on me 5 ☐ Resid 28d. Describe h 28f. Location (S City or Tow	lence low inju	ary occurred) Route Number,
ב	Hospite 4 hours Funeral	edical Ce		Physician: To the											
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	July	mor stated.			License					ate signed (M		
	1941		30. Name and address of person was SUKH DEV S. AUJI	A, M.D.,	VA MAI	RYLAND I	Print) HEALTI	HCARI		STEM,					902
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0	7 2005	Registrar's Sign	nature	barte	j							

			1 - For Stete Registrar	State of Maryland / Dep Ce	artment of Health and M rtificate of Death	⁄lental Hygie Reg.	
	Physici	an	1. Decedent's Name (First, Middle, Last)	Dougon Ir		2. Date of Death Month	Day Year 3. Time of Death
	/Media	cal	Landreth Wayne			December	30, 2004 6:2/ P M
	Examir	ner	4a. Facility Name (If not institution, give s Sinai Hospital	treet and number)	4b. City, Town, or Location of Death Baltimore		4c. County of Death
	Funeral Director		5. Social Security Number 2 1 7 - 06 - 45 1 1 6. Sex	M 2□ F 7. Age (In yrs. last birthday, Yrs.		8. Date of Birth	9. Birthplace (State or Foreign Country) MD
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	Maryli -f sho	tor	MD	Baltimor			1 L Yes 2 □ No
	h with the	al Director	10e Street and Number 3804 Bonner Rd.		101. Zip Code 21216	10g.	Citizen of What Country?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23e or 28e-f show or other treumetic event, Ire Medical Examination in the India at the models of the treumetic event.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:Black
5-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade	cation 16a. Dece completed) (Give	dent's Usual Occupation kind of work done during most of work	ing 168	b. Kind of Business/Industry
21215-0036	r within iene.	Completed by	1 Th	College (1-4or 5+)	kind of work done during most of work DO NOT use retired) OCK CLERK	R	ecieving
land 2	12 should be filed within ? h and Mental Hygiene. 7 Is marked other then " freumetic event, It e Med	To Be C	17. Father's Name (First, Middle, Last) Landreth Bowser	Sr.	18. Mother's Nam Sandra	e (First, Middle, Mai Jackson	iden Sumame)
Maryland	t and 2 shou Health and N tem 27 is mar other treumet		19a. Informant's Name/Relationship (<i>Typ</i> Sandra Wright	ре, Print) 19b. Mail 3 8 0 4	ng Address (Street and Number of Rue Bonner Ro. Ba	al Route Number, C. LIMOTE,	MB Torm Style & Code)
Baltimore,	ges 1 a t of Hei If item or othe		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ R	amoval from State 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	matory or other place) 1 – 6 -	Date 200	c. Location - City or Town, State
Itim	t. Pa tmer tent:		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral S ce License	VVoodla	wn Cemetery	15	altimore Co
Ba	permi Depar Impor eny ir		Meslen /	Phanely 2	2. Name and Address of Ficility Wes 2007 Eastern Ave	e. Balti	more, MD2 231
ā			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)		unshotwour		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con equence of):			
	p =	ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
1	icate be executed physician and the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
68760,	e be ex sician e buria	dical E		but to (or as a consequence or).			
_		Medic					
О. Вох	at the death certifi by the attending tached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ls, P.	es that gned by be deta	by Ph	Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ords	v require been sig should b					1 ☐ Yes	2 No 3 Probably 4 Unknown
Vital Record	The lay ate has page 2	Completed				24a. Was an autopsy performed	
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	Othor	Check on one	
of		: To	1XXYes 2 No 27. Manner of Death	28a. Date of Injury 28b. Time of		me 5 Residence	e 6 Other (Specify)
ion	Attending I death. ctor: After y the funer	atlor	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	PM 1 Tyes 2 No	Sub	1ect Shot
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town, Si hucill	Ind Number or Rural Route Number, tate) 3600 Block & AVE. Baltmare WL
	d 7 4 E	edical (29a. Certifier 1 Certifying Phys (Check only one)	icien: To the best of my knowledge, deat er: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause	e(s) and manner as stated.
	To the Hos within 24 ho To the Fun completely f	Mec	29b. Signature and title of certifier	and marrier stated.	29c. License number	29d.	Date signed (Month, Day, Year)
}			(eurol Ha	llan md	O.C.M.E.	Dece	ember 31, 2004
_	2		30. Name and address of person who could have a contract to the contract of th		Penn Street, Balt:	imore, Mar	ryland 21201
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 7 200	32. Agistrar's Signature	nach		

## Aberdeen Function Functio	00a ^M or Foreign City Limits s 2 □ No
## Aberdeen Function Functio	or Foreign
Second Security Number 0.5 Sex 216-16-9843 Second Security Number 0.5 Sex 216-16-9843 Second Security Number 0.5 Sex 216-16-9843 Second Security Number 0.5 Sex 216-16-9843 Second Security Number 0.5 Sex 216-16-9843 Second Security Number 0.5 Sex 216-16-9843 Second Security Number 0.5 Sex 216-16-9843 Second Security Number 0.5 Sex 0.5 Se	City Limits s 2 □ No
10a. State 10b. County 10d. Inside 10f. Town or Location 10d. Inside 10d. 10d. In	s 2□No
Howard Baldwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	ny
Howard Baldwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	ıy
Howard Baldwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	ıy
1 Separate Composition Separate Separa	
1 Separate Composition Separate Separa	
Physician / Medical Examiner Physic	ИD
Shock, or heart failure. List only one cause on each line. Interval Be Onset and Ideas or condition resulting in death) Physician / Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Due to (or as a consequence of): Due to (o	078
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last Columbia	etween
FEMALE: 23d. Date of delivery Short Shor	
23c. If yes, outcome of pregnancy 1	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 1 Yes all No 3 Probably 4	Year
	death?]Unknown
24a. Was an autopsy finding prior to completion of death? 25. Was case referred to medicat examiner? 25. Was case referred to medicat examiner? 26. Place of Death (Check only one)	available cause of
25. Was case referred to medicat examiner? 26. Place of Death (Check only onl) 1	
25. Was case referred to medicat examiner?	nber,
29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	s)
1 Mone Scullin 1 37364, December 29, 20	OCL
30. Name and address of Derson who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Mohr) Pay (Year) 2005 32. Registrar's Signature	

			1 - For State Registrar	State of Maryla		artment of H		Mental Hy	/giene Reg. No.2004	1,2586
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last	Conn	ay	Col	vin	2. Date of Do Month De Ceiv	eath Day Year 1ber 31 200	1
1	Examir Funeral	ner	4a. Facility Name (If not institution, give 5 + - (- 1 2 M e + 4) 5. Social Security Number 6. Se.	VWSing 7. Age (In yrs	Cente	4b. City, Town, or If Under 1 Year Months Days	Location of Death B A + If Under 24 Hrs. Hours Min.	imore	4c. County of Dea	th thplace (State or Foreign buntry)
	Director		577-34-0540 112 Usual Residence of Decedent 10a. State 10b. County	M 2□F 75	Yrs.		Hours Min.	July 1	1929 Wasi	nington, DC
	death with the Maryland ms 23a or 28a-f show rmust be rollf of a	Funeral Director	Maryland Baltimor		tonsvi	lle				10d. Inside City Limits 1 XYes 2 No
	with t	Ö	10e. Street and Number 19 Winters Lane,	106		10f. Zip Code			10g. Citizen of What Co	ountry?
	death	era	11. Marital Status	12. Was Decedent Ever in I	J.S. 13. V	21228		Decify Yes or N	U.S.A.	erican Indian
920	permit. Pages I and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or liems 23a or 28a-1 shov any injury or other traumatic event, If I Mudical Examinst must be rediffed any once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cuba	Specify:	o Rican, etc.)	Specify: Bla	e, etc.
215-0	within 72 ho ene. than "natur ne Medical	Completed	15. Decedent's Edu (Specify only highest gradi Elementary/Secondary (0-12)	e completed)	(Give	ent's Usual Occupa kind of work done of OO NOT use retired,	during most of wor	king	16b. Kind of Business	Industry
21	ad with	Com	Clementary/Secondary (0-12)	College (1-4or 5+)	Pri	nt Shop	Manager		Print S	hop
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, ILAIN ONCE.	To Be	17. Father's Name (First, Middle, Last) William C. Colvin				Fannie	Mae Ta		
Mar	12 sho h and 7 Is m raum		19a. Informant's Name/Relationship (Ty						er, City or Town, State, 2	Zip Code)
	1 and Healt em 2	1 8	Britt C. Colvin (S		DIZ W		Rd., Bal	timore,	MD 21229 20c. Location - City or	Town State
ο̈́	ages ant of nt: If it		1 Burial 2 □ Cremation 3 □ R `4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, crem	atory or other place am. Ceme			Warrenton	
Baltimore,	mit. F partme portan r injur		21. Signature of Funeral Service License				-			, VA
ä	Deparenti Deparenti Importany in		Lennis Os	allmein-	P	Name and Addres Oynes Fu .O. Box	neral Ho 3633 Wa	me, Inc rrenton	VA 20188	
8760,	/Medical Examiner bhysicien and bruial-transit sthe burial-transit	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a))).	quence of):	structi	ive pu	(mon		Approximate Interval Between Onset and Death
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregni 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3 🔲	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
rds, P.	w requires that been signed b should be det	by	Part II. Other significant conditions con Hypertems	tributing to death but not res	sulting in the un	dertying cause give	n in Part I.		obacco use contribute to	. /
Il Records,		Completed						24a. Was autop perfo 1 \(\text{Yes} \)		opsy findings available ompletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Deat			
of	Phys this al dii	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death		ER/Outpatient 28b. Time of	3 DOA Other	4 Minursing Ho		dence 6 Other (Spec	ify)
O	ding I th: : After s funer	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury Work? M 1 □ Y	at ? ′es 2 □ No	zod. Describe r	now injury occurred	
Division	al or Attendi safter death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, streety)			28f. Location (S City or Tow	Street and Number or Ru n, State)	ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death tion and/or inve	occurred at the time estigation, in my opi	e, date and place, inion, death occur	and due to the o	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	2 1 1	2.0 -	29c. License	number		29d. Date signed (Month	, Day, Year)
)			100	i thu	w	D S	5-34	1	January	4, 2005
	2		30. Name and address of person who con	Benson /	tren	rint) Le, B	altim	ore A	lary land	7, 2005
	Sta Registra		31. Date filed (Monfn, Day, Year) JAN 1 1 20	32. Pigistrar's Signa	ture da	noted			1	

			1 - For State Registrer	State of Marylan	d / Depa	artment of H tificate of L	ealth and l Death		giene 004	42587
P	Physici		1. Decedent's Name (First, Middle, Last) Charlotte H. Cus	simano				2. Date of Dea Month Dec.	Day 2004	3. Time of Death 9.00 P M
	/Medic Examin		4a. Facility Name (If not institution, give st 241 Baltimore Av			4b. City, Town, or Dundal		h	4c. County of Death	a
	Funeral Director		5. Social Security Number 402-50-7030 Usual Residence of Decedent	M 2 7. Age (In yrs. 66		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		(Year) 9. Birth	place (State or Foreign ntry)
	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23s or 28s-f show or other treumatic avent. Ite Modical Examiner mat be mailled at	Funeral Director	10a. State 10b. County Md. Baltimor 10e. Street and Number 241 Baltimore Ave.	re	y, Town or La	nda1k 10f. Zip Code 21222		1	log. Citizen of What Coul	10d. Inside City Limits 1 ☐ Yes 2 ☑ No ntry?
9036	ours after des ral', or Items	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	ł	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes ※☐ No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		
21215-0036	e filed within 72 h al Hygiene. i other then "netu vent. It e M. JELI	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of wo	rking	16b. Kind of Business/In Own Home	dustry
Maryland	should be filed nd Mental Hygin marked other umatic avent, II	To Be C	17. Father's Name (First, Middle, Last) Estel Pennington			a Chicke I		me <i>(First, Middl</i> e, t tta H. Ju		
	1 and 2 should be Health and Mental tam 27 is marked: other traumatic av		19a. Informant's Name/Relationship (Typ Joseph Cusimano	/ Husband	241	Baltimo		Dundalk	r, City or Town, State, Zip Md. 21222	
altimore,	permit. Pages 1 Department of He Important: If itan any Injury or oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	amoval from State Ba1	emetery, crer to-Was	sition (Name of natory or other place sh.Cremato	ory 1-	Date 6-05	Laurel, Md.	
Ba	Depar Depar Impor any In		21. Signature of Funeral Service Licenser	Tracet	Br		nton-Mat		nc. 2134 Wil	
8760,	Physician /Medical Examiner b attending physician and of for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a collised	uence of):	Inall cell			9	Interval Between Onset and Death
O. Box 6	the che	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
rds, P.	w requires that been signed by should be deta	d by	Part II. Other significant conditions cont	tributing to death but not res	ulting in the u	nderlying cause give	en in Part I.		bacco use contribute to t es 2 □ No 3 □ Prot	he cause of death?
Vital Records,	The law ate has b page 2 sl	Complete						24a. Was a autope perfor	sy prior to co med? death? 2☑No 1☐Yes	opsy findings available impletion of cause of
of	Attanding Physician: Treath. r death. ector: After this certificat by the funeral director, p	ation: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injun Work	er: 4 ☐ Nursing H		ence 6 □Other (Special ow injury occurred	59)
Division	E Pige	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str y)	eet, factory, office		28f. Location (S City or Town	treet and Number or Rura n, State)	al Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edicai	(Check only 2 Medical Examin	sician: To the best of my kno ner: On the basis of examina and manner stated.	ition and/or in	vestigation, in my o	oinion, death occi	urred at the time, o	date and place, and due to	o the cause(s)
)	To To Conf	Σ	29b. Signature and title of certifier Purcell	Stoff Styrice	ian	29c. License	number	2	1/3/05 Timek Multi	uay, real)
	Ŋ			mpleted days of dath (Iten	v M ←	Print) 4140 E.A.	CIERT A	1/c, BA-1	Timor my zi	2-24
,2	Sta Registi		31. Date filed (Month, Day Year) 0 2	2005 32. Refistrar's Signa	Ature A	porte				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 0 0 4

42588

	Physici	an	1. Decedent's Name (First, Middle, Last) Dorothy Collison							2. Date of De Decemb	er en,	2004	3. Time of Death 0110A.
	/Medic Examin		4a. Facility Name (II	f not institution, giv	e street and number nie's Bead	-)			or Location of Death Frederick		4c. Coun	nty of Death	
	Funeral Director		5. Social Security N 213-27-4	994	6ex 7. A	ge (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan. 1	th ay, Year) 4, 1988	Cou	place (State or Foreigr intry) Yland
	e Maryland	ctor	Usual Residence of 10a. State MD	10b. County Anne Ar	undel		r, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with the 23a or 28	Funeral Director	10e. Street and Num P.O. Box		O Linden	Avenue	2	10f. Zip Code	1106		10g. Citizen o	f What Cou	ntry?
920	72 hours after death with the Maryland naturel', or Items 23a or 28e-f show dical Examinar must be notified at	by	11. Marital Status 1XXVever Marri 3 ☐ Widowed	ed 2 Married	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	? X No		Was Decedent of I f Yes, specify Cub I ☐ Yes ※XXNo	Hispanic Origin? (Spann, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Spec	ace - Ameri lack, White, city: W	
21215-0036	within ane. than "	Completed	(Spec	15. Decedent's Edify only highest grandary (0-12)		5+)	16a. Deced (Give life. L	during most of work.	ing	16b. Kind of Business/Industry		idustry	
Maryland 2	be file stal Hy od oth event	To Be Co	17. Father's Name ((First, Middle, Last,			beau	=1112	18. Mother's Name Kelley				
			19a. Informant's Na Nicholas		Турө, Print) n (Father)			and Number or Rura , 120 Lind				
Baltimore,	Page: ent o nt: If				Removal from State	9 6	emetery, cren	sition (Name of natory or other pla Mem. Gard	ce) dens 01/04) Ale	20c. Location		
Balt	permit. Departm Importe eny inju		21. Signature of Fu	neral Service Lice	fun		22	Name and Address Hardesty 12 Ridge	ess of Facility y Funeral ely Avenue	Home P	.A. polis,	MD 21	401
100	Pnysician		shock, or hear Immediate Cause (disease or condition	rt failure. List only Final	ploations that cause one cause on each	line.			ng, such as cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
1	/Medical Examiner	ier	resulting in death) Sequentially list corif any, leading to im	mediate III	Due to (or a	s a consequ	uence of):						
8760,	cate be executed by sician and the burial-transit	ai Examiner	cause. Enter Unde Cause (Disease or that initiated events resulting in death) L	injury	c Due to (or a	s a consequ	uence of):						
87	hysi the l	dicai			d								

attending p Be Completed by Physician/Me Medical Certification: To

To the Hospitel or Attending Physicien: The law requires that the death certif

Division of Vital Records, P.O. Box

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

4☐ Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 2 1 No 1 🗌 Yes 3 Probably 4 □Unknown

24a. Was an autopsy performed? 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

POLE

25. Was case referred to medical examiner?
1 Yes 2 □ No 27. Manner of Death 1 Natural
2 Accident

5 Pending investigation 6 Could not be

determined

1 Inpatient 28a. Date of Injury (Month, Day Year) 12-31-04 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Time of Injury 0110 D M

Other: 4 Nursing Home 5 Residence 6 Mother (Specify Scene)

28d. Describe how injury occurred

PD>SOWISMIN MOTORATERS STRUCK 28f. Location (Street and Number or Rural Route Number, City or Town, State) RTZ61 & BROWNED BEDCK RD COLVENTON

29a. Certifier (Check only one)

3 🗌 Suicide

4 | Homicide

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

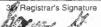
Hospital:

0.C.M.E.

29d. Date signed (Month, Day, Year) December 31, 2004

of death (Item 23a) (Type, Print) 11 Penn St., Baltimore, Maryland 21201

State Registrar 31. Date filed (Mooth, Pay, Year,



RODOWAY

within 24 hours a To the Funerel [

			Tor State Registrar	State	of Maryla	and / Depa	artmen rtificate					giene	004	42589
ı	Physici	an	Decedent's Name (First, Middle,	,							2. Date of De Month	Day	Year	3. Time of Death
	/Medic		Amelia Dalesio-		umber)		4b. City.	Town. or	Location of		Decembe		ounty of Dea	10:55 a M
	Examir	ier ∌	Greater Baltimo	•	,	ter		timo				10.0	n/a	
	Funeral		Social Security Number 6	. Sex	7. Age (In y	rs. last birthday)	If Under				8. Date of Bir (Month, Da	th Voas		thplace (State or Foreign
	Director		220-01-6255	1□M 2□F	82	Yrs.	Months	Days	Hours	Min.	Feb. 10	19	22 Ma	ryland
	and *		Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	cation							10d. Inside City Limits
	/ sho	ō		1										1 Yes 2 No
	28e-	Director	Md. Harf	ora		rai	1ston 10f. Zip					10a, Citiza	en of What Co	
	3e or	D	3320 Hazelwood	Drive					21047	7			.S.A.	, .
	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show dical Evarinet must be notified at	Funeral	11. Marital Status	12. Was De	cedent Ever in	U.S. 13.	Was Deced	ent of Hi	spanic Orig	igin? (Spec	cify Yes or No lican, etc.)		4. Race - Am	
õ	or Ite		1 Never Married 2 Married		2 No		1 ☐ Yes		Specify:		noan, etc.)		Black, Whi Specify:	te, etc.
2-003e	hours uret',	d by	3 ★Widowed 4 Divorced	Year or	Dates:									white
<u>.</u>	in 72 in 78	Completed	15. Decedent's (Specify only highest	grade completed		(Give	dent's Usua kind of wor DO NOT us	k done o	turina most	t of workin	g	16b. Kind	d of Business	/Industry
7 7	d with piene. r ther	mo	Elementary/Secondary (0-12) 7 years	College	(1-40r 5+)	home	maker	ĺ				ow	n home	
aud,	e tilec al Hyg othe vent,	BeC	17. Father's Name (First, Middle, La	ist)					18. Mothe	er's Name	(First, Middle,	Maiden S	iumame)	
<u> a</u>	Ments Ments arked	70	Raphael Dalesio						Ange	line	Fiori			
Mar	2 sho		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rural	Route Numbe	er, City or	Town, State,	Zip Code)
o, S	1 and 1ealth 1m 27		Nancy Dalesio/n	iece	201	3320 D. Place of Dispo	Haze.	Lwoo	d Dri		Fallsto			
5	ages or of the		1 ☑ Burial 2 ☐ Cremation 3		n State	cemetery, crei	natory`or or	ther place				20c. Loc	ation - City or	Town, State
Saltimor	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: it item 27 is marked other then "neturet', or Items 23e or 28e-f show empty or other treumetic event, the Medical Examinat must be notified at ance.		 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice 		G	ardens o	of Fa:				/2005	Ba1	timore	, Md.
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П			232 Part1. Enter the disease, or co shock, or heart failure. List or	mplications that	caused the de	ath. Do not ent	$610~\mathrm{W}$ er the mode	• Ma	cPhai g, such as	1 Roa	respiratory ar	Air	, Md.	21014 proximate
	Pnysician	s 10	Immediate Cause (Final disease or condition	ny one cause on	Hear	1/2 00	46 0	120	1/2/	/	refer -	100	υ .	Interval Between Onset and Death
	/Medical		resulting in death)	aDue to	(or as a cons	equence of):				0	seles			
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	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a cons	equence of):								
-	certiticate be executed Iding physician and use as the burial-transit	хап	that initiated events resulting in death) Last	c	(or as a cons	equence of):								
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Z OZ	w requires that the death certific been signed by the atlending p should be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of preg		Ectopic pre	annancy				23	d. Date of del	•
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spiosa	r requ	etec	Englie Vs	ida	4/1	82H						1		
D D	he fav	ompieted									24a. Was autop perfor		prior to death?	itopsy findings available completion of cause of
	incate	ပို	25. Was case referred to medical						Of Plans	of Dooth		200	1 🗆 Yes	2 No
>	ysicie s cert direct	0 0	examiner?	Hospital: 1	Inpatient 2	RVOutpatien	t 3 🗆 DO	A Othe			e 5 ☐ Resid		Other (Sne	cufy)
5	ig Ph ter th	T :uc	27. Manner of Death	28a, Date	of Injury nth, Day Year)			Bc. Injury Work	at		3d. Describe h			
VISION	endii eath. or: Al	catic	2 Accident investigat	tion			М		res 2□N	No				
Ž	or Att	ertification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	288. Plac	e of Injury - At ding, etc. <i>(Sp</i> e	t home, farm, str cify)	eet, factory	, office		28	Bf. Location (S City or Ton	itreet and m, State)	Number or Ru	ıral Route Number,
ב	To the Hospitel or Attending Physicien: The law within 24 buous alter death. To the Funerel Director: Alter this certificate has completely tilled in by the funeral director, page 2.	O	20a Cartifier	Physician: T- "	o bost of	nowledge desi		4 6b = 1'-	a data	d plans	ad due to the		-d	atatad
	B Hos 24 hc B Fun etely 1	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the aminer: On the and mai	ie best of my k basis of exami nner stated.	ination and/or in	occurred a vestigation,	in my op	e, gate and inion, deat	u piace, ar th occurred	d at the time, o	ause(s) a date and p	na manner as lace, and due	to the cause(s)
	To the within Fo the comple	Me	29b, Signature and title of certifier	/			29c	License	number,	507	_		signed (Monti	
			1 SEA	040	Page			//	53	>07		12.	10	0 %
	r 1		30. Name and address of person wh	no completed cau	use of death (It	tem 23a) (Type,	Print)							
	-		Eddie Nakhuda, N	M.D., 23	00 Dula	aney Val	Lley I	Road	, Lut	hervi	lle, M	d. 21	1093	
	Sta Registr		31. Date filed (Month, Day Age)	7 2005	Registrar's Sig	nature	14034	Le la						= .
	ricgisti	-				-								

	Please 1	ype or Print in State of Maryla	nd / Departm	ent of H	ealth and		9	001
			Certific	cate of L	Death		Reg. No.	UU4 425
	1. Decedent's Name (First, Middle, Last)	2 1				2. Date of De		3. Time of De
Physician /Medical	Dozathy	Dusston				Decemb	Dey Der 26.	Yeer 2004 8:46 a
Examiner	4a Fecility Name (If not institution, give	treet end number)	Home	4	b. City, Town, or	Location of Deet		
Funeral	5. Social Security Number 6. Sex		Mon	nder 1 Year ths Days	If Under 24 Hrs Hours Min		th Vear	Birthplace (State or Fo Country)
Director	215-07-8579 Usual Residence of Decedent	lm 2⊉F	90 Yrs. Mon	ths Days	nours Min	Nov 4	-	MD MD
within 72 hours efter deeth with the Meryland ene. than "natural", or items 23s or 23s-f show he Medical Examinat must be notified at mpleted by Funeral Director	10a. Stete 10b. County	10c. C	City, Town or Location					10d. Inside City L
vith the Me t or 28s-f s be notified	MD Baltimor	e Mo	onkton					1 □ Yes 2
e se e	10e. Street end Number		10f	. Zip Code			10g. Citizen of	What Country?
23 ar	14903 Dunstan Lane			1111				States
r home 23st street must street must	1	12. Was Decedent Ever in Armed Forces?	U,S. 13. Was De	ecedent of Hi specify Cuba	spenic Origin? (5 n, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Rad Bla	ce - American Indian, ck, White, etc.
Y F	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		s 25 No	Specify:	,	Specif	
d b	3 Widowed 4 □ Divorced	Year or Dates:						White
nati	15. Decedent's Educ (Specify only highest grede	cation completed)	16e. Decedent's l (Give kind o	Usual Occupa I work done o	ation luring most of wo)	rking		usiness/Industry
Depmit. Pages 1 and 2 should be find within 72 hours effer deeth with the Meryler Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If I term 27 is marked other than "natural", or flerns 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be northad at once. To Be Completed by Funeral Director	Elementery/Secondary (0-12)	College (1-4or 5+) 5+	Homemake)		Own Hor	me
al Hygis I other went, II	17. Fether's Name (First, Middle, Lest)				18. Mother's Na	me (First, Middle	Maiden Surnan	ne)
n end Mental I is marked of raumatic eve	Albert Philip Car	l Krieger			Rebecca	Small		
To Be Co	19a. Informant's Name/Relationship (Type	ое, Print)	19b. Mailing Add	ress (Street a	and Number or R	urel Route Numb	er, City or Town,	, Stete, Zip Code)
Health Health om 27	Mr. Albert K. Duns		14903 Di	unstan	Lane, M	onkton,	MD 2111	1
of He	20a. Method of Disposition	20b.	Place of Disposition (cemetery, crematory	(Name of or other place	9)	Date	20c. Location -	- City or Town, Stete
nent of I	1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	t. John's			Dec 30 2004	Sweet A	Air, MD
permit. Pag Department Important: P any injury o once.	21. Signature of Funeral Service License		22. Name	e and Addres	s of Facility			
	1 Stale	MUOTO		mation 7 Gree	and Fur n Pastur	neral Al ces Driv	ternativ e Balt:	ves imore, MD
hysician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death) e	Acute Due to	Dwortcu (or es a consequence	litis				
cian en bunel-tr. nsit	Cause (Disease or injury	Due to	(or es e consequence	of):				
d by the ettending physician leteched for use es the bune Physician/Medical E	that initiated events resulting in death) Last	Due to (or as a consequence	of):]
0 2 -	Part II. Other significant conditions con	ributing to death but not re	sulting in the underlyin	ng cause give	n in Part I.		tobecco use co Yes 2□ No	ntribute to the cause of de 3 ☐ Probably 4 ☑ Onk
should should					·		en autopsy rmed?	24b. Were autopsy finding available prior to completion of cause of death?
						101	100 2 ETNG	1 ☐ Yes 2 ☑ No
ertifica ector, Be (25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only o	ne)	
	1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐	I DOA Othe	r: 4 K. Nursing H	lome 5 ☐ Resi	dence 6 □Oth	ner (Specify)
	27. Menner of Death 1 ☑Naturel 5 ☐ Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury Work	et ?	28d. Describe	now injury occur	red
death. ctor: Aft y the fur ficatio	2 ☐ Accident investigation	(, 25, . 54.)	M		es 2□No			
# = #	3 Suicide 6 Could not be determined	28e. Plece of Injury - At I building, etc. (Spec	nome, farm, street, fac ify)	ctory, office		28f. Location (3 City or Tox	Street and Numb vn, State)	per or Rural Route Number,
Funer Funer Tely fill	29a. Certifier 1 Certifying Phys (Check only one)	cian: To the best of my kn er: On the basis of examin end manner stated.	owledge, death occurr ation end/or investigat	red et the time tion, in my op	e, date and place inion, death occu	, and due to the rred at the time,	ceuse(s) and me date and place,	enner as stated. and due to the cause(s)
within 2 To the comple	29b. Signature and title of certifier			29c. License	number	T	29d. Date signe	d (Month, Dey, Yeer)
> - 0	Inlibrate I/x	luc		H45	5931		12/29/	04
in	30. Name and address of person who cor	()_	m 23e) (Type, Print)			- RAIT	MICAGE	MO 2120
State	31. Dete filed (Months Park Year) 7 70	32. Segistrar's Sign		17516	ITS INE	DATE	MURE	140 2120
Registrar	SHIM A 1 50	UD ROBERTO	13. Apart					

			1 - For State Registrar	State of I	Marylar	nd / Depa		t of He	ealth a	and M	ental Hy	Reg. No.	004	42591
	Physici	an	1. Decedent's Name (First, Mid	- 00						1	2. Date of De Month	eath Day	Yeer	3. Time of Death
	/Media	cal	Donald	L.		Dodso					Decemb		2004	10:10 p ^M
1	Examir	ner	4a. Facility Name (If not institute North Arunde1		er)			n Bu	Location o	of Death			nty of Deat	
	Funeral		5. Social Security Number	-	Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Bir		9. Birtl	undel hplace (State or Foreign
	Director		307-70-7101	1 X M 2□ F	42	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da April	2, 196:	Co	olorado
	pug A		Usual Residence of Decedent 10a. State 10b. Coun	tv	10c Ci	tv. Town or Lo	eation							10d. Inside City Limits
	f sho	ō		Arundel		asaden								1 ☐ Yes 2 ☑ No
	r 28a	rec	10e. Street and Number	Ardider		asauci	10f. Zip	Code	·			10g. Citizen o	of What Co	
	ier death with the Marylar Items 23a or 28a-f show Irat must be notified at	Funeral Director	165 Meadow Ro	ad				2	1122				USA	
	r dea	ner	11. Marital Status	12. Was Decede Armed Force		.S. 13.	Was Deced	lent of His	panic Ori	gin? (Spe	cify Yes or No Rican, etc.)	14. R	ace - Ame	erican Indian,
36	s afte	by Fu	1 ☐ Never Married 2XXMa 3 ☐ Widowed 4 ☐ Divorce	If Vac Give		1	1 ☐ Yes 2				,	1	oify: Wh	
8	i within 72 hours after death with the Maryland liene. Tithan "natural", or Items 23a or 28a-f show The Medical Examiliar must be notified at	ed t		ent's Education	15.	16a. Dece	dent's Usua	il Occupat	tion			16b. Kind of	Business/	Industry
215	within 7% ene. than "ni	plet	(Specify only high Elementary/Secondary (0-12	nest grade completed)	or 5+)	(Give	kind of wor DO NOT us	rk done du se retired)	uring mos	t of workir	ng			
7		Completed	11			Tech	nicia							Air Cond.
pur	e d a b	Be	17. Father's Name (First, Middle									Maiden Sum	ame)	
Maryland 21215-0036	⊇ Se te	2	Luther Henry 19a. Informant's Name/Relation			10h Mailie	a Addross	(Stroot or			ryn Re	ed er, City or Tow	- Canan 3	7:- 0:- 4:-
Ma	0 0 0 0		Tina M. Dodso									D 21122		Ip Code)
	ss 1 and 2 of Health item 27 i		20a. Method of Disposition		20b. F	Place of Dispo cemetery, crei		-			ate	20c. Location		Town, State
E	Page nent o int: If iry or		1 Burial 2 remation 4 Donation 5 Other		110	tro Cr			1	01/03	/2005	Baltir	nore.	MD
Baltimore,	permit. Pages Depertment of I Important: If ite any injury or of		21. Signature of Funeral Service	e Licensee				-			lome, P			
	70 E 2 9	0 0	J. C - 26.	Ju-			12 Ri	dgel	y Ave	enue,	Annap	olis, N	1D 21	401
	Physician /Medical		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	st only one cause on each	sed the deat h line. NOXI as a conseq	,	rde					rrest,		Approximate Interval Between Onset and Death
	Examiner		Conventially list and distance	b. Dr	49	Ove	rde	5-6						3 2 1145
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a opnseq									
	ecute and I-trans	Examiner	that initiated events resulting in death) Last	c.	as a conseq	uence of):								
8760,	cate be executed physicien and the burial-transit	ical E			a3 a conseq	dence or).								
687	ificate g phys	edic		d.										
Вох	The law requires that the death certific. Ite has been signed by the attending pl page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor 1 ☐ Live birth			Ectopic pre	anancv					Date of deliv	•
O. E.	ne dea the at hed fo	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□Unknowr	t at time of d		Other (spe					N	Month	Day Year
P.0	res that the de igned by the a be detached t		Part II. Other significant condi	tions contributing to deat	h but not res	ulting in the u	nderlying ca	use giver	n in Part I.		23e. Did to	obacco use co	ntribute to	the cause of death?
Records,	quires n sign uld be	ed by									101	res 28No	3 ☐ Pro	obably 4 Dunknown
Ö	aw requin s been si 2 should b	Completed									24a. Was		. Were aut	topsy findings available
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Vital	Physician: Th r this certificate ral director, pag	Bec	25. Was case referred to medic examiner?						26. Place	of Death	Check onl o			
of \	S S =	은	1 Yes 2 No			ER/Outpatien		A Other	: 4 □ Nu			dence 6 🗆 O		ify)
uc Ou	De et e	lon	27. Manner of Death 1 Natural 5 Pend	aning .	Day Year)	28b. Time of Injury	28 M	3c. Injury a Work?	at es 2.⊠1			med 1		10,05
Division	Attending r death. ector: After by the fune	fical	3 ☐ Suicide 6 Coul	10100				_	2 2 2					ral Route Number,
ă	al or /	Certification:	4 Homicide	building,	ic. (Specif	y)	,				ty or Tou	vn, State)		10
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: Af completely filled in by the fu	edical (29a. Certifier 1 Certify (Check only one) Certify	ring Physician: To the be al Examiner: On the basis and manner	st of my kno s of examina	wledge, death tion and/or inv	occurred a restigation,	at the time in my opi	, date and nion, deal	d place, a th occurre	nd due to the d d at the time,	cause(s) and n date and place	nanner as , and due	stated. to the cause(s)
•	To the within 2 To the complet	Me	29b. Signature and title of certif	ier	Deg	a fel	29c.	License	number	54	,	29d. Date sign	ed (Month)	Day, Year)
	V		30, Name and address of person	n who completed cause of	60		Print)	01	n		rica			
	Sta	to	31. Date filed (Month, Day, Yea	(r) 32. Regi	istrar's Signa	ture L	0	75	12	ne	VICA	3	103	5 7
	Sta Registr		JAN (7 2005	Gere o	B. A	bark	,						

			•	State of Maryla	ınd / Depa		ealth and I	Mental Hygi		
	Physici /Medic	al .	Decedent's Name (First, Middle, Last) J. T. E7 4a. Facility Name (If not institution, give sti			4b. City, Town, or L	ocation of Death	2. Date of Death Month DECEMBER	Day Y	3. Time of Death
	Examin Funeral Director		BRIGHTON GARDENS 5. Social Security Number 6. Security Number		s. last birthday) Yrs.	COLUMBIA			HOWARI) Birthplace (State or Foreign Country) GEORGIA
	P	tor	257-03-6608 Usuat Residence of Decedent 10a. State 10b. County MARYLAND HOWARD	10c. (City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 28a	al Director	10e. Street and Number 7110 MINSTREL WAY	1		10f. Zip Code 20145			g. Citizen of Wh	at Country?
036		by Funeral	11. Maritat Status 1 Never Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Agned Forces? 1 Eyes 2 □ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cuban	panic Origin? (S , Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. VHITE
215-0036	within 72 hours after ene. then "natural", or ite he Modical Exemina	Completed	15. Decedent's Educe (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	iring most of wor	rking	6b. Kind of Busi	ness/Industry
Maryland 2121	uld be filed w Aental Hygier rkad other th tic event, the	To Be Cor	12 17. Father's Name (First, Middle, Last) WILLIAM LONEY ETHE	2 RIDGE	MILIT	CARY OFFIC	18. Mother's Nan	ne (First, Middle, N		
	nd 2 should lith and Men 27 is marks r traumatic	•	19a. Informant's Name/Relationship (Type TIMOTHY ETHERIDGE			ng Address (Street ar 1515 MIDWA				
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marks eny injury or other traumatic. 000ce.		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation Cher (Specify)	moval from State		sition (Name of matory or other place				ity or Town, State
Balti	permit. Departm Imports eny inju		21. Signatury of Juneral Service Licensee	Lenton	Q 22	DEMAINE F 5308 BACK	of Facility UNERAL (LICK RD.	CHAPEL ., SPRING	FIELD, V	
)	Physician /Medical Examiner		23a Part 1. Enter the disease, or complic shock, or heart failure. List only one trimmediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	gestus gestus equence pf): one	e kea	such as cardiac A fa Cauline	c or respiratory arre	st,	Approximate Interval Between Onset and Death
3760,	ate be executed ysician and he burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a cons	equence of):	brillal	in			
O. Box 68	Attending Physician: The law requires that the death certificate reads. reads. setor: After this certificate has been signed by the attending physic the funeral director, page 2 should be detached for use as the	by Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pre 1 Live birth 2 Fi 4 Pregnant at time of 9 Unknown	etat death 3	Ectopic pregnancy Other (specify)			23d. Date Month	
S	uires that I n signed by uld be deta	d by Ph	Part II. Other significant conditions cont	ributing to death but not i	-	4	n in Part I.		acco use contrib s 2 □ No 3	ute to the cause of death?
Vital Record	The law re ate has bee page 2 shu	Completed						24a. Was ar autopsy perform 1 Yes 2	/ prid	ore autopsy findings available or to completion of cause of ath?
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	ER/Outpatier 28b. Time o Injury	of 28c. Injury Work	r: 4 □ Nursing H	ath Check only one dome 5 Reside 28d. Describe ho	nce 6 Other	
Division of	al or Atten after deat I Director: d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - A building, etc. (Spe	t home, farm, str ecify)	reet, factory, office		28f. Location (Str. City or Town		or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Divicempletely filled in I	edical C	29a. Certifier (Check only ane) 29a. Certifying Physical Control only and a control only a control only and a control only a control only a control only a control only a control only a control only a control only and a control only a control	cien: To the best of my left: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the time vestigation, in my opi	e, date and place inion, death occu	e, and due to the ca urred at the time, da	use(s) and manr ite and place, an	ner as stated. d due to the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	In w)	29c. License	number 0870	29	d. Date signed (Month, Day, Year) -11-2005
	3		30. Name and address of person who cor	npleted cause of death (I	item 23a) (Type,	Bell La	ne (larles	ulle 1	-11-2005 MD 21024.
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	houle 8				

	4 101	epartment of Health and N Certificate of Death	Mental Hygiene Reg. No. 2004 42593
Physiciar /Medica	Donard Raymond Baposico		2. Date of Death December 31, 2004 7:45 а м
Examine	A = 100 Alone of and to the state of the sta	4b. City, Town, or Location of Death Timonium	4c. County of Death Baltimore
Funeral Director	5. Social Security Number 6. Sex 1	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) April 2, 1929 9. Birthplace (State or Foreign Country) New York
h the Maryland r 28e-f show Incillied at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Md. Harford Bell 10b. Street and Number 10c. Street and Number 10c. City, Town of Bell 10c. Street and Number 10c. City, Town of Bell 10c. Street and Number 10c. City, Town of Bell 10c. Street and Number 10c. City, Town of Bell	or Location Air 10f. Zip Code	10d. Inside City Limits 11☑ Yes 2 ☐ No 10g. Citizen of What Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show eney injury or other treumatic event, the Medical Eventries must be notified at 2000s.	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Takher's Name (First, Middle, Last)		Rican, etc.) Black, White, etc. Specify: white
ole, Maly es 1 and 2 sho of Health and N if item 27 is ma or other treums	19a. Informant's Name/Relationship (Type, Print) 19b. Mary Ellen Esposito/wife 214 20b. Place of Disposition	A Crocker Drive, Be	al Route Number, City or Town, State, Zip Code) 1 Air, MD 21014 Date 20c. Location - City or Town, State
Physician /Medical Examiner the burial-fransit		22. Name and Address of Facility Schimunek Funeral 610 W. MacPhail R tenter the mode of dying, such as cardiac	Home of Bel Air, Inc.
death certif		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
est bed	Part II. Definer significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
2 2 8 9			24a. Was an autopsy performed? 1 Yes 2 140. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
F E E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp.	atient 3 DOA Other: 4 Nursing Ho	n (Check only one) me 5 ☐ Residence 6 ØOther (Specify) HO Spice 28d. Describe how injury occurred
To the Hospitel or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Modical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
he Hospi in 24 hour he Funer pletely fill	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, of the basis of examination and/of and manner stated.		
To the within To the Committee Commi	29b. Signature and fittle of certifier 30. Name and address of person who completed cause of death (Item 23a) (T)	29c. License number D43725	29d. Date signed (Month, Day, Year)
State Registra	Dr Taria Mahmod 2300 31. Date filed (Moprin Pay, Year) 2005		y Rd Timonium, Md

December 31,2004

Amend ietm#10e,19b per INF C839,1/7/05 TT
State of Maryland / Department of Health and Mental Hygiene 2004 42594 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 28 FIELDMAN **Physician** Month Year ANL DECEMBER 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBACUTE SALTIMIE RANDAUS TOWN NONTHWEST | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb 20, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1፟፟፟∭ M 2□ F 217-20-1764 77 Director Maryland Usual Residence of Decedent with the Maryland 10a. State MD 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or items 23a or 28e-f show the Medical Examiner must be notified at Carroll Taneytown 1 Yes 27 No Director 8 Bancroft 10f. Zip Code 10g. Citizen of What Country? Street 21787 death USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iten eny injury or other traumatic event. The Medical Exercited ODES. Black, White, etc. 1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates: 45-47 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify þ white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel Fieldman Helen Rosenfeld ပ Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Bancroft Street
Taney town, MD 21787 19a. Informant's Name/Relationship (Type, Print) Mary Lucille Fieldman/spouse Taneytown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 21. Sign renti Euneral Service Licensee State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): iding physician and ise as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 4/11 No certificate 1 ☐ Yes 20 NO Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ 💢 Hospital: Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Anatural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No investigation hours after deat uneral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide within 24 hours a To the Funeral I pellij 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) 77333 30. Name and address of person who completed cause of death (Item 23a) (Type, TO MD 2/13] MO NHE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

			1- State Registrar Registr	Mental Hygie	ene2004 42595
	Physic /Med	ical	1. Decedent's Name (First, Middle, Last) TATIANA ASNAWNTE' GRAVES 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea		Day Year 3. Time of Death 29 04 0740 AM
#1	Funera Directo	1	Harford Mem Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 I Under 1 Year If Under 24 Hr 2/8-06-5230 1 Mem 2/8 20 Yrs. Months Days Hours Mir	s. 8. Date of Birth	HARFORD 9. Birthplace (State or Foreign Country)
Stor	with the Maryland a or 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Aberdeen 10e. Street and Number 10f. Zip Code	100	10d. Inside City Limits 1 1 Yes 2 No 1. Citizen of What Country?
Ves	6 after death or Itema 23	Funerai	2 Robsevel Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 1 Never M		14. Race - American Indian, Black, White, etc.
y ra	1215-0036 within 72 hours after ene. then "natural", or lite medical Evaralists	Completed by	15. Decedent's Education (Specify only highest grade completed) [Specify only highest grade completed) [Indicator (Specify only highest grade completed) [Indicator (Specify only highest grade completed) [Indicator (Specify only highest grade completed)	orking 16	Specify: BIACK ib. Kind of Business/Industry
2	vre, Maryland 212: s 1 and 2 should be filed within or Health and Mental Hygiene. Item 27 is marked other than other traumatic event, Ire.M.	To Be Co	BRYANT GRAVES Sheila		
ian	Baltimore, Maryland : perrit. Pages 1 and 2 should be filed opportment of Health and Mental Hyg important: If Item 27 Is marked other may nigury or other traumatic event,		19a. Infofmant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F 5/10: 1/1 GRANCS - Modified - 10 Color of Community (Name of Community) 20a. Method of Disposition 1 □ Burial 2 Coremation 3 □ Removal from State	Date 20	2160 / c. Location - City or Town, State
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	Prrysiciar /Medica Examine		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to or as a consequence of):	ac or respiratory arrest	Approximate Interval Between Onset and Death
	760, te be executed ysician and te burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):		
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39/	Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this cartificate his completely filled in by the funeral director, page	ation; To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No		ce 6 ☐Other (Specify) injury occurred
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	\		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kannelm Milham mo 1106 Revolution St. +	10000	Grave MD 21078
d	S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Covicate	your months

•	1		State of Maryland					•	
		•	1 - For State Registrar		tificate of l			1. No 2004	62596
	Physicia	an	1. Decedent's Name (First, Middle, Last)	/			2. Date of Death Month	Bay X9ar	3. Time of Death 72/5A M
	/Medic	al	4a. Facility Name (If not institution, give street and number)	ž	4h City Town or	Location of Death	12 0	4c. County of Death	1010A M
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. le		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Birthpla	ace (State or Foreign
	Director		215-64-9461	Yrs.			6-17-	52	Md.
	yland now		10a. State 10b. County 10c. City	, Town or Lo				10	d. Inside City Limits
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9	after o	Fun	Armed Forces? Never Married 2 Married 1 Yes & No Yes, Give		fYes, specify Cuba 1 ☐ Yes 2 🕱 No	ispanic Origin? (Spenn, Mexican, Puerto	Rican, etc.)	Black, White, e	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. sthar then "natural", or Items 23a or 28e-f show ant, Ite Medical Exam ner must be routified at	d by	3 Widowed 4 Divorced Year or Dates:						ack —————
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p	be filed tal Hygi id othar avant, I	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			
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ore,	of Health of Health itam 27		20a. Method of Disposition 20b. Pl	ace of Dispo	sition (Name of natory or other place			c. Location - City or Tov	vn, State
Ĕ	Pages ment of ant: If it ury or o		1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		Mem. Park		05	Randallsto	wn, Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28e-1 show any injury or other traumetic event, I've Medical Exaltine or must be notified at once.		21. Signature of Funeral Service bicensee	22	March F.	•	Balt 1101 I	timore, Md. E. North Ave	21202 e.
			23a. Part 1. Enter the disease, of complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory arres	t,	Approximate Interval Between Onset and Death
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<u>а</u>	that the	y Ph	Part II. Other significant conditions contributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to the	cause of death?
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E 20		Con	HYPER TENS	3100	J		performe 1 □ Yes 2	death?	No No
Vite Etc	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 1	ED/Outpotion	Other		(Check only one)	ce 6 Other (Specify)	
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	tha Ho lin 24 I tha Fu	ledical	one) and manner stated.	ion and/or in					
\	To To	Σ	29b. Signature and the objectifier	n	29c. Licens			ANUALY	
	/)	1	30. Name and address of person who completed cause of death (Item	23a) (Type	Print)	3170	0	LINN HEY	1 2005
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		I. Decedent's Name (First, Middle, Last) Samuel Reeser Hi	Samuel Hu	tson, Si			2. Date of Death Month December	Day Year 2004	3. Time of Death 4 12:15 P
Aedica aminei		la. Facility Name (If not institution, give st	treet and number)		4b. City, Town, or		December	4c. County of Dee	
annine		7615 Washington Bou	ılevard, I	Room 23	Jessup			Howard	
eral ctor		5. Social Security Number レ ドル 6. Sex 145	M 2□F Z	(In yrs. last birtho 44 Yr	Months Days	Hours Min.	8. Date of Birth (Month Day, Y ec. 5, I	960 9. Bir	thplace (State or Fore ountry) TENN
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Ever directional be rediffed at	5]	Maryland Howard		Columb	ia				1 ☐ Yes 2 ₹
be notified	3 -	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	ountry?
ust k	ב ב	10353 Twin Rivers			21044			U.S.A.	
instranst		T. Maria Clares	2. Was Decedent Ev Armed Forces?	ver in U.S.	 Was Decedent of His If Yes, specify Cubar 	panic Origin? (Spec i, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Am Black, Whi	
PAGE 1	J.	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:	,	1 ☐ Yes 2 🖾 No	Specify:		Specify: Wh:	ite
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t, the		8		C	onstruction	10 Mathada Nama		Construct	ion
	Ď	17. Father's Name (First, Middle, Last) Reeser Hutson				18. Mother's Name Iva Ne11			
matic	2	19a. Informant's Name/Relationship (Typ	ne Print)	19b. N	Mailing Address (Street a				Zip Code)
trau		Reeser Hutson (Fat			. Box 2002			-	p 0000)
other	-	20a. Method of Disposition		20b. Place of D	Disposition (Name of crematory or other place	D		c. Location - City or	Town, State
ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State		ers Bend Ce			Church H	Iill, TN
any injury or other tra		21. Signatur of Funeral Service Licens	fool d Q(00	22. Name and Addres Johnson F 320 Grand	s of Facility uneral Ho view St.,	me Church	Hill, TN	37642
inq e	cal Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of					
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Maryland / Department of Health and N Certificate of Death	
		Decedent's Name (First, Middle, Last)	2. Dete of Deeth 3.7 Time of Deeth U
Physici		EMMANUEL ANDRE HARRIS	Month Day Year 12 27 2004 6:23 AH
/Medic Examin		EMMANUEL ANDRE HARRIS 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or L	
		MERCY MEDICAL CENTER BALTING	NECITY Baltimore City
Funeral Director		5. Social Security Number 6. Sex 1 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) 12 26 04 MAR IIA	
V	۱ ا	Usuel Residence of Decedent	100 00 0 1 11/10 11A NO
arylan ahow	_	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Ne Mi Sa-f	95	m B BAltimore	1 No Yes 2 □ No
Ind 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. I other than "natural", or flems 23a or 23s-1 show vent, the Madical Examiner must be notified at	Funeral Director	1807 Morth BOND STREET 2/2/3	10g. Citizen of What Country?
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5-0036 72 hours aft natural; or	þ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Detes:	Specify: BIACH
72 r 72 r	ete	15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of work life. DO NOT use retired)	ing 16b. Kind of Business/Industry
Maryland 21215-0036 d 2 should be filed within 72 hours at the and Mental Hygiene. 7 Is merked other than "natural", or traumatic event, the Medical Exami	Be Completed	Elementery/Secondary (0-12) College (1-4or 5+)	
faryland 21 2 should be filed w and Mental Hygier Is marked other th	Be		e (First, Middle, Maiden Surneme)
Via ould Merke	ဥ	ANDRE BEALE HARRIS TAMITA	
		TAMITY A. W. 11 iAMS NOTHER 1807 MORTH BOND ST	rel Route Number, City or Town, State, Zip Code) BAIIs MD 2/2/3
		20a. Method of Disposition 20b. Place of Disposition (Name of cemetary crematory or other place)	Date 20c. Location - City or Town, State
altimo nit. Pag artment ortant: I Injury o		4 Donation 5 Other (Specify)	/11/05 Woodlawn, MD
Baltimore, pemit. Pages 1 ar Department of Hea Important: If Hear 2 any Injury or other once.			wab Funeral Home, INc.
	\neg	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	Baltimore, MD 21228 or respiratory errest, Approximate
Physician		shock, or heart failure. List only one cause on each line.	Interval Between Onset and Death
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) e. RESPIRATORY DISTRESS SY	NDRAHE
Examiner	_	Due to (or as e consequence of):	
nsit	edical Examiner	Sequentially list conditions, b. PULMONARY HYPERTENS Due to (or es e consequence of):	ION
'60, ba axecuted sician and burial-transit	Exai	if env. leading to immediate	
68760, ificate ba ax physician as the burial	cal	cause (Disease or injury that initiated events Due to (or as e consequence of):	NDLOHE
68 tifical ng phy as th	_	resulting in deeth) Last	18 WEEKS GA)
Box 6 auth certifi	an	d 32/3/3 4 MEDIA ORTHY (2	8 WEEKS GA)
t the daa by the att	SICI	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
Vital Records, P.O. Box 68760, siclan: The law requires that the death certificate be assect certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transpace.	by Physician/M		1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
cords v requiras been sign	ed b		24a. Was an eutopsy performed? 24b. Were autopsy findings available prior to
SCOF aw requ is been 2 shoul	Completed		completion of cause of death?
I Rec Tha law ata has t	ĕ		1 Yes 2 No 1 Yes 2 No
f Vital I ysiclan: Th s certificata diractor, paq	BeC	25. Was case referred to medical examiner? 26. Place of Deat	h (Check only one)
of Vita Physiclan: this certific	2	Hospital: \2	me 5 Residence 6 Other (Specify)
⊏ 2° ₹ €	Ë	1 □ Natural 5 □ Pending (Month, Dey Year) Injury Work?	28d. Describe how injury occurred
ision ttending death. stor: After	cat	2 Accident investigation 3 Suicide 6 Could not be	
Division of or Attending Physical death. Director: Attenthis lin by the funeral di	Certification:	4 ☐ Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)
epital ours ours rfillad	2	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause(s) and manner as stated
Divisio To the Hospital or Attendia within 24 hours after death. To the Euneral Director: A completely filled in by tha fa	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	red at the time, date and place, and due to the cause(s)
Withiu To the Comp	Σ	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	-	▶ for 2. Suttrbt, M.D. 2000358	1-3-2005
		30. Neme end address of person who completed cause of death (Item 23e) (Type, Print) RONALD L、GUTBERLET, M、D:	DICAL CENTER
Sta		31 Date filed (Month Day Year) 32 Begistrer's Signature	MICHECEN (E)C
		JAN 1 1 2005 Street & Specific	
Registr			
DHMH 16 Rev 6/9		ORIGINAL	

				•		epartment of F		-		
			1 - For State Registrar	otato or mar		Certificate of			200	4 42590
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Bernard Howard	Horton				12	31 20	
	Examir	ier	4a. Fecility Name (If not institution, give str	reet and number)		4b. City, Town, or	Location of Death		4c. County of Dee	th
1.			College I 5. Social Security Number 6. Sex		C In yrs. last birth		rville	9 Date of Birth	Baltimo	ore County
80	Funeral Director			M 2□F	83 Y	Months Days	Hours Min.	8. Date of Birth (Month, Day,	1921 M	rthplece (State or Foreign ountry)
)		Usual Residence of Decedent		0- C'- T-			- 1 - 1		Traction in the second
200	ehow del	2	10a. State 10b. County MD Baltimor		0c. City, Town	herville				10d. Inside City Limits 1 ☐ Yes 2X No
A dt	28a-f	Director	10e. Street and Number		Бас	10f. Zip Code		10	g. Citizen of What C	
with	3a or	Ī	30 W. Seminary Ave	nue		76 2	21093		USA	,
death	1382	nera	11. Marital Status	2. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe	ecify Yes or No-	14. Race - Am Black, Whi	
d 21215-0036 filed within 72 hours after death with the Maryland	or Its	by Funeral	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	unk	1 ☐ Yes 2 1 No	Specify:	moan, etc.)	Specify:	white
21215-0036 ad within 72 hours at	tural al Ex	q pa	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education	Year or Dates:	16a D	ecedent's Usual Occup	ation	unk 1	6b. Kind of Business	
	Medic	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind of work done of the contract of the	during most of worki	ng dille	ob. Kind of Dagings	Tildosily CIIR
212	giene er the	Completed	unk un							
<u></u>	od oth	Be	17. Father's Name (First, Middle, Last)			unk	18. Mother's Name	(First, Middle, Mi	aiden Sumame)	unk
aryla should	nd Mer mark matic	ဥ	19a. Informant's Name/Relationship (Type	e. Print)	19b. A	Mailing Address (Street	and Number or Rura	l Route Number	City or Town State	Zin Code)
;, Ma	ulth ar 27 Is r trau		Paul Feeley/attorn	•	1	07 Courtlan				
Je j	Item othe		20a. Method of Disposition	I	20b. Place of C	Disposition (Name of crematory or other place	(e)	ate 2	Oc. Location · City or	Town, State
im Face	ant: If its		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☒ Donation 5 ☐ Other (Specify)	moval from State						
Baltimore,	Department of Health and Mental Hygiene. Important; or Items 23s or 28s-1 ehow eny injury or other traumatic event, the Medical Examinat must be notified at once.		2 consture Laneral Service censes	ades price	tor	State and Address Baltimore,	•		Ealtimore	Street
ecuted	hysician and Medical xaminer fransit to privide privide privide provide transit to the privile provide transit to the privile	Examiner	23a. Part. Enter the disease or complicity shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of	izocardia				Interval Between Onset and Death Munulto
I Records, P.O. Box 68760, The law requires that the death certificate be ex	attending physic for use as the bu	Physician/Medical	d. IF FEMALE: 23b, Was decedent pregpart 23	c. If yes, outcome of			=1 =1		23d. Date of de	livery
D. Geat	ed by the atted	hysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 [4 ☐ Pregnant at tim 9 ☐ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
Vital Records, P.	n signed uld be det	by	Part II. Other significant conditions control	ributing to death but r		he underlying cause giv	en in Part I.		cco use contribute to	o the cause of death?
O ME	s been si 2 should	Completed	dementia					24a. Was an autopsy	24b. Were a	utopsy findings available completion of pause of
	ate has page 2	Com						performe	death?	
/ita	certificate rector. pag	Be (25. Was case referred to edical examiner?				26. Place of Death	(Check only one,		
o d	h. After this funeral di	tion: To	1 Yes 2 No 27. Many of Death 1 Najural 5 Pending 2 Accident investigation	espital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	28b. Tin	ury Wor	4 Inursing Hor	ne 5 🗌 Residen 28d. Describe how	ce 6 □Other (Spe rinjury occurred	cify)
5	s after deatl	Certification:	3 Suicide 6 Could not be determine 1	28e. Place of Injury building, etc. (n, street, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	urel Route Number,
To the Hospital	within 24 hours of To the Funeral completely filled	edical (29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of rest: On the basis of earlier and manner states	amination and/	death occurred at the tin or investigation, in my o	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	se(s) and manner a e and place, and du	s stated. a to the cause(s)
Tota	To the comp	¥	29b. Signature and little of certifier	(1)	a	29c. License	e number	290	d. Date signed (Moni	h, Day, Year)
			- Duce	Kasi	ulle	(g/W)	D24121	/.	2/31/04	
			30. Name and address of person who com	pleted cause of deal	h (Item 23a)	9 e, Print	70	Taukan	de s	1204
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's	Signature	B .O	ーラー	NOCHAL	, MD 2	207
d.E.	Registr		JAN 1 1 200	5 Beene	At A	jours				

GRI	K.S EGORY				Department of Health and Certificate of Death	Mental Hyg	
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last, GREGORY LOUIS HOI Facility Name (If not institution, give LAUREL REGIONAL)	HL	4b. City, Town, or Location of De-	2. Date of Deat Month	h Day Year 3. Time of Death 23, 2004 1840 P M 4c. County of Death
	Funeral Director		5. Social Security Number 6. Security Number 1 216-64-2164		LAUREL birthday) If Under 1 Year If Under 24 H Months Days Hours Mi		PRINCE GEORGES 9. Birthplace (State or Foreign Country) NEW JERSEY
5-0050 72 hours after death with the Maryland	Sa-f ahow	Director	Usual Residence of Decedent 10a. State 10b. County MD PRINCE GE(,	wn or Location		10d. Inside City Limits 1 🛱 Yes 2 🗍 No
eath with th	s 23a or 24 out the no		10e. Street and Number 3 MORTON PLACE	10 Was Dandert Free in II C	10f. Zip Code 20707		Og. Citizen of What Country? U.S.A.
ours after de	tural', or Itams 23a or 28a-f ahow al Examinet must be notificed at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 □ Yes 2 ☑ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
within	r than "natu It e Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) Coltege (1-4or 5+)	ia. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired) SUPERVISOR	orking	16b. Kind of Business/Industry
should be filed	evant,	To Be Co	17. Father's Name (First, Middle, Last) DONALD G. HOHL		18. Mother's N	ame (First, Middle, M	Maiden Sumame)
5, IVIGIT, 1 and 2 sho	tem 27 Is marke other traumatic		19a. Informant's Name/Relationship (Ty BRIAN HOHL/SON 20a. Method of Disposition		3 MORTON PLACE LAURI of Disposition (Name of	EL, MD 207	
Dermit. Pages 1 a	rtant: If		1 Burial 2 Cremation 3	temoval from State GATE	of HEAVEN CEM. 1-04 22. Name and Address of Facility FI	4-05 S	ILVER SPRING, MD
1 2 2	any ir		23a. Part1. Enter the disease, or complishock or heart fallure. List only or	DIDOW locations that caused the death. Do ne cause on each line.	7601 SANDY SPRING onot enter the mode of dying, such as cardi	ac or respiratory arre	est, Approximate toterval Retween
te be executed	attending physician and tor use as the buriat-transit	dicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence). Due to (or as a consequence). Due to (or as a consequence).	e of):		
that the death certifica	the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. tf yes, outcome of pregnancy 1 □Live birth 2 □ Fetat dea 4 □ Pregnant at time of death 9 □ Unknown	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
equires that	sign d be	by	Part II. Other significant conditions cor	ntributing to death but not resulting	in the underlying cause given in Part I.	10	acco use contribute to the cause of death?
ician: The taw requires t	ate has page 2	Completed				24a. Was ar autops perform Yes 2	prior to completion of cause of death?
	s certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1XXYes 2 \(\times \) No	lospital:	Other	eath (Check only one	
l or Attending Phy after death.	tor: After this certific the funeral director,	\vdash	27. Manner of Death 1 Satural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No			
the of	Dirac in by	i Certification:	3 Suicide 6 Could not be determined	eet and Number or Rural Route Number, State)			
na Hos	To the Funeral I	Medicai	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	ner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occurred.	ce, and due to the ca curred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
To tha	Totl	×	290. Signature and the of certifier	us	29c. License number O.C.M.E	29	DEC. 25, 2004
	12		30. Name and address of person who co	7.00 111 PE	ENN STREET, BALTIMORI	E,MARYLANT	21201
	* Sta		31. Date filed (Month, Day, Year) JAN 0 7 2005	32. Registrar's Signature	barki		

				1 _ State	Department of Health at Certificate of Death	nd Mental Hygi	eng 1014 12601
		Physici /Medic		1. Decedent's Name (First, Middle, Last) HAZEL E . HENSON	Octunicate of Death	2. Date of Death Month December	Day Year 10 243
		Examin		4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center	4b. City, Town, or Location of Bel Air	Death	4c. County of Death Harford
		Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 10 M 20 F 80		4 Hrs. 8. Date of Birth Min. 6/26/19	
		Maryland -f show	tor		wn or Location		10d. Inside City Limits 1 ☐ Yes 2 No
J		a or 288	I Director	10e. Street and Number 1971 Whiteford Road	10f. Zip Code 21160	10	g. Citizen of What Country?
03	36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "netural", or Items 23e or 28e-1 show avent, the Medical Exertine transt be incitified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Vorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Vo No If Yes, Give X Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☑ No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
4	15-0036	in 72 hour n "netural Aedical Ex	Completed t	15. Decedent's Education (Specify only highest grade completed)	Sa. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	of working	6b. Kind of Business/Industry
ナッ	d 2121	12 should be filed within n and Mental Hygiene. Fis marked other than "reumatic avent, the Men	Be Com	Elementary/Secondary (0-12) College (1-4or 5+) 10 17. Father's Name (First, Middle, Last)	Seamstress 18. Mother	s Name (First, Middle, M	Sewing Factory
3	Maryland	d 2 should be th and Menta 7 is marked traumatic av	To B	Lawrence Glasgow Scarborough		Neeper	Ohan Tana Chan The Coatal
3		and 2 sh ealth and m 27 is n		19a. Informant's Name/Relationship (Type, Print) Kenneth L. Scarborough/Son	9b. Mailing Address (Street and Number 1030 Timber Lane,	Orange Cit	y, FL 32763
	Baltimore,	of H		20a. Method of Disposition 1 (XBurial 2 Cremation 3 Removal from State \$\frac{1}{2}\text{To Donation} \text{ 5 Other (Specify)} 20b. Place \$\frac{2}{2}supplies of the supplies of the	of Disposition (Name of tery, crematory or other place) e Ridge Cemetery 1	/5/2005	Oc. Location - City or Town, State Delta, PA
	Balti	permit. Page Department of Important: If any injury or QDCe.		21. Sign store & Funeral Service Licenses	22. Name and Address of Facility Harkins Funeral Hor		St.,Delta, PA 17314
. 4		Fnysician	k M	23a Part 1. Either the disease or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	o not enter the mode of dying, such as co	ardiac or respiratory arres	Approximate Interval Between Onset and Death
1514		/Medical Examiner		resulting in death) Due to (or as a consequence	e of):		
2916	0,	eath certificate be executed attending physician and for use as the burial-transit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last b. Due to (or as a consequence consequence)			
	68760	icate be physicia s the bur	dlcal	d			
72+	.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death	tth 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
F	ds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did toba	accoluse contribute to the cause of death?
~	Records	ne faw req has been ge 2 shou	ompleted	atrial & brillation		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
0	ital		Be Co	25. Was case referred to medical	26. Place (perform 1 Yes 2	No 1 Yes 2 No
S	of V	Physic this ceral direct	၉		Outpatient 3 DOA Other: 4 Nurse. Time of 28c. Injury at	sing Home 5 Residen	
11	sion	ending Ph eath. or: After th	catlon	Matural 5 ☐ Pending (Month, Day Year) investigation	Injury Work? M 1 Yes 2 N		y injury coodings
F	Divi	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
		To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director.	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowled and manner stated.	ge, death occurred at the time, date and and/or investigation, in my opinion, death	place, and due to the cau n occurred at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)
)	To the To the comp	Σ	29b. Signature and title of certifier HULDYULUM	29c. License number		1. Date signed (Month, Day, Year) Clubble 3 , 2004
/		7		30. Name and address of person who completed cause of death (Item 23:	i) (Type, Print)	regland	
		Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Enzelle B	0	

DHMH 17 Rev 1/2001

	1. Decedent's Nan	ne (First, Middle	, Last)					-,	2	2. Date of De	Reg. No eath Da			ne of Death
ician dical	Ronnie									DEC.		2004		30 P M
niner	4a. Facility Name 2367 W	(If not institution ASHINGT	o, give street and nui ON BOULEV	mber) ARD				Location of ORE C	ITY		4c.	County of De	eath	
al or	5. Social Security 215 – 46 -	-9548	6. Sex M 2 □ F	7. Age (In yrs.	last birthday) 57 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	3. Date of Bi (Month, Di 3 - 22-	rth a <i>y, Year)</i> 47	9. E Ker	Birthplace (St. Country) ntcky	ate or Foreign
	Usual Residence	of Decedent 10b. County		10c. C	ty, Town or Lo	cation							10d. Insid	le City Limits
Ď	MD			Ra l	timor	0								Yes 2 □ No
Funeral Director	10e. Street and N	umber		Daı	CIMOI	10f. Zip	Code	-			10g. Cit	izen of What	Country?	
alD	2367 Wa	shingt	on Blvd	•		212	230				USA	A		
ner	11. Marital Status			edent Ever in U	J.S. 13.	Was Decede	ent of Hi	spanic Origi	in? (Speci Puerto Ri	fy Yes or No	0-	14. Race - Ar Black, W		n,
		rried 2 Marr	ied 1 ☐ Yes If Yes, Giv	2X No		1 □ Yes 2		Specify:				Specify:Wh		
ed by	3 E3 Wildowed	4 Divorced	Year or D	ates:	16a Daga	dent's Usual	I Occupa	ation			16h K			
Completed		cify only highes	st grade completed)	1.4	(Give	kind of worl	k done d e retired,	furing most (of working	7	100. K	ind of Busines	samuustry	
OTH	Elementary/Sec	ondary (0-12)	College (1-4or 5+)		ston					Cons	struct	on	
Be C	17. Father's Name	(First, Middle,	Last)					18. Mother	s Name (First, Middle				
To B	Boyd He	nsley						Bess	ie M	larti	n			
,	19a. Informant's !		hip (Type, Print)		19b. Mailie	ng Address	(Street a					r Town, State	a, Zip Code)	
	Anna He											MD.		
	20a. Method of Di		3 □Removal from	State 20b.	Place of Dispo cemetery, crea	sition (Nam matory or oti	ne of ther place	θ)	Da	te	20c. Lo	ocation - City	or Town, Stat	е
	° 4 ☐ Donation	5 Other (S	pecity)	Ва	yview									
	21. Signature of F	uneral Service	Licensee D	.0								s Jr.		
	W	este	complications that confly one cause on e	ms) 2	007 E	Cast	ern	Ave.	Bal	to.	MD 21	231	imate Between
dical Examiner	Sequentially list of any, leading to cause. Enter Unicause (Disease othat initiated even resulting in death)	15	c	(or as a consec										
by Physiclan/Med	IF FEMALE: 23b. Was decede in the past 1 1 ☐ Yes 2 9 ☐ Unknow	2 months? □No		oirth 2 Fet	al death 3	Ectopic pre						23d. Date of o	delivery Day	Year
ed by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of the cause of the cau													
Completed											psy ormed?/	prior to death	autopsy findi o completion ? es 2 No	ngs available of cause of
Φ	25. Was case refe	erred to medical						26. Place of	of Death (1 ☐ Yes Check only		1	65 20 140	
To B	examiner?	□No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗆 DO/	A Othe					6 V.Other (Sp	pecify) AT	SCENE
-	27. Manner of Dea	ath 5 🗌 Pendin	28a. Date (Mon	of Injury th, Day Year)	28b. Time o	28	Bc. Injury Work			d. Describe				
:uc	2 Accident	investi	gation		, , ,	М		res 2□N	0					
atlon:	3 Suicide	6 ☐ Could	inned 286. Place	of Injury - At h ing, etc. (Speci	iome, farm, str fy)	eet, factory,	, office		28	f. Location (City or To	Street an wn, State	d Number or	Rural Route	Vumber,
Sertification:	4 Homicide	determ												
edical Certification:			g Physicien: To the Exeminer: On the b and man	e best of my kn asis of examin ner stated.	owledge, deat ation and/or in	h occurred a vestigation,	at the tim in my op	e, date and pinion, death	place, an occurred	d due to the at the time,	cause(s) date and	and manner I place, and d	as stated. ue to the cau	se(s)
Medical Certification:	4 Homicide 29a. Certifier (Check only	1□ Certifyin 2□ Medical XX	Exeminer: On the b and man	e best of my kn asis of examin ner stated.	owledge, deat ation and/or in	vestigation,	in my op	e, date and inion, death number .M.E	place, an occurred	d due to the	date and	and manner I place, and divide signed (Mo. C. 26,	ue to the cau	

State Registrar 31. Date filed (Month, Day, Year) JAN 12 2005

MARyson

you

KUREN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

32. Registrar's Signature

O.C.M.E.

December 24, 2004

			Amend Items 23	State b,24a,25,	of Marylan 26,27,29	d/Depa a per	rtment of H	lealth and l 01/10/05 Death	Mental Hy odhb	rgiene 2 Reg. No.	004	4260
	Diversitation		1. Decedent's Name (First, Mide	die, Last)					2. Date of De	_	Year	3. Time of Death
	Physicia /Medic		Edward B. J	ames					Dicen	her 16	2004	11 12 M
	Examin	_	4a Facility Name (If not institution	on, give street and n	number)			4b. City, Town, or L	ocation of Deat	h 4c. Count	y of Death	
		· On	Crescent Ci	ties Cent	er			Hyattsvi			nce Ge	orge's
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth ay, Year)	Country	e (State or Foreign
	Director		579-26-8395	1 M 2 □ F	78	Yrs.	,		July 21	1926	South'	Carolina
	D .	H	Usuel Residence of Decedent 10a. Stete 10b. Count	N	10c City	, Town or Loc	ation				104	. Inside City Limits
	aryla sho	۲ ا		ce George		attsvil					100	1 ☐ Yes 2 💢 No
	N 94 N 1 N 1 N 1 N 1 N 1 N 1 N 1 N 1 N 1 N	Director			,		,			10a. Citizen of	Mh et Counte	
	a di	늄	10e. Street and Number	h 114 alaan			10f. Zip Code	20700		•		*
	within 72 hours after death with the Maryland ans . than "natural", or items 23s or 28s-f show he Madical Exerciner must be notified at	Funeral	4404 East West		andont Everin III	C 10 W	In a December of the	20783	anait. Van an Ne		SA ce - American	Indian
	them them	Š	11. Marital Status	Armed F	ecedent Ever in U,	5. 13. W	Yes, specify Cub	lispanic Origin? (Sj an, Mexican, Puert	o Rican, etc.)	Bia	ick, White, etc	
20	rs aff	by F	1 Never Married 2 2 Ma 3 Widowed 4 Divorce	If Yes. C			☐ Yes 2XINo	Specify:		Speci	v: bla	ck
응	n 72 hours "natural", adical Exa	8	1100000	ent's Education	Dates: WWI		ent's Usual Occur	pation		16b Kind of F	Business/Indus	stry
15	in 72	흥	(Specify only high	est grade completed		(Give k	ind of work done O NOT use retire	during most of work	king			,
12	withing and then then	Completed	Elementary/Secondary (0-12)		(1-4or 5+) ()	driv	zer			1 im	ousine	
ğ	e filad el Hygia other vent, tr	Ö	17. Father's Name (First, Middle	a, Last)				18. Mother's Nam	ne (First, Middle			
Maryland 21215-0020	lid be lentel ked c	To Be	Willie Jam	es				Idora J	. Linbe	rry		
ar.	shound Minner	-	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailing	Address (Street	and Number or Ru			, State, Zip Co	ode)
	nd 2 lith e 27 is r tra		Pearlie James/	spouse		6707 I	Darkwood	Court Fo	restvi1	le. MD	20747	
ē,	iges 1 and 2 should be filed within to filed health and Mentel Hygiana. If item 27 is marked other than or other traumatic event, the Menter tra	1	20a. Method of Disposition		20b. P	lace of Dispos	ition (Name of atory or other pla		Date	20c. Location		State
Ę	Pages nent of int: if its		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🕅 Other (n State	эттөтөгү, стопт	atory or other pla	00)				
Baltimore,	보투원을 .	- 1	21. Signature of Funeral Service				Name and Addre	ss of Fecility				
ä	Depa impo any l		Ronald	S. Wade,	virector	St	ate Anat	omy Board		Baltim	ore St	reet
-	-	-	232 Part Enter the disease	or a molications that	caused the death		ltimore,			rreet	Α,	pproximate
40	Dhysisian		23a. Ph.1. Enter the dise ve, of shock or heart failur. Lis	st only one cause on	each line.	50 1101 5110	. ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	·9,			ln in	terval Between nset and Death
-/	Physician /Medical		Immediate Cause (Final	A	Ten	12 Cel	onatio	Cardio	10 (0)	A 10	10 1	1-01-1
	Examiner		disease or condition resulting in death)	a. 1) 1		r as a consequ		Carato	MUMA	المال الدام		Jun _
		ē			Due to (of	as a consequ	ierice or).					
	that the daath cartificate be axecuted ed by the attending physicien end detached for use as the buriel-transit	Examiner	Sequentially list conditions	b	Due to (or	as a consequ	ence of):					
oʻ	axec en en riel-tr	<u> </u>	Sequentially list conditions, If eny, leading to immediate cause. Enter Underlying									
68760,	te be ysicie e bu	dicai	Cause (Disease or injury that initiated events	c	Due to (or	es e consequ	ence of):					
89	tifica ng ph as th	2	resulting in death) Last					· · ·				
Вох	v requires that the daath cartifi been signed by the attanding should be detached for use as	Physician/Me		d					-		1	-
H	daa oe att ed fo	<u>s</u>	Part II. Other significant condit	ions contributing to	death but not resu	ılting in the un	derlying cause giv	en in Part I.	23b. Did	tobacco use co	ontribute to th	e cause of death?
P.0	at the	됩	heriche	al vas	12.116	Nid	294		1 🗆	Yes 2□ No	XX Probab	dy 4 □ Unknown
s,	as the	<u>م</u>	1)27, pries	THE ONLY	scoray	-310	299		-			
ğ	requires seen sign should be	2	•							an autopsy ormed?	availa	autopsy findings ble prior to
ပ္ထ	aw re as be 2 sh	be									of dea	letion of cause ath?
œ .	The law ata has t page 2 s	Completed							10	Yas XX No	1 🗆 Y	es 2□ No
Vital Records,	ysician: The law iis certificata has t I director, page 2 s	Be	25. Was case referred to medic	al				26. Place of Dea	th (Check only	one)		-
>	Physician: r this certific ral director,	2	examiner? 1 ☐ Yes 2 ▼No	Hospital: 1	Inpatient 2 1	ER/Outpatient	3□ DOA Oth	ner: 4X Nursing H	ome 5 ☐ Resi	dence 6 □Ot	her (Specify)	
n of	ig Ph ter th neral		27. Manner of Death 1 ▼Natural 5 □ Pend	/4.40	e of Injury onth, Day Year)	28b. Time of Injury	28c. Injui Wo	y et rk?	28d. Describe	how injury occu	rred	
<u>.</u>	Attending r death. sctor: After by the fune	뛽	2 Accident inves	tigetion			M 1	Yes 2 □ No				
Division	after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could determ	mined 200. P120	ce of Injury - At ho ding, etc. (Specify		et, factory, office		28f. Location (City or To	Street and Num wn, State)	ber or Rural R	oute Number,
	rs aft ai Di	Š										
	lospi 4 hou uner aly fil	edical	(Check only 2 Medica	ing Physician: To the Examiner: On the	ne best of my know basis of examinet	vledge, death	occurred at the tip estigation, in my o	me, date end place,	, and due to the rred at the time,	cause(s) and m date and place,	anner as state and due to th	id. e cause(s)
	2727	S S	one)	and ma	nner steted.		- 63			29d. Date signo		
	OF NO PO		29b. Signature and title of certification	1 1.1	. 0		29c. Licens		2	_		
			in the	new	my		DC	1103		Utcem	ner 29	2004
	3		30-Name end address of person	who completed cer	MD Yw	23e) (Type, P	rint)	Du W.	6tten!	Decem	1 7 . 2	21
	_	4	31 Date filed (Month Day Von		Registrer's Signet		73130107	1-4 179	121.14.00	, , ,,,	IJ LUIC	J /
w.	Stat Registra	~	31. Date filed (Month, Day, Year	111170 555	1.	Ann	No B					
	negistic			Patition of the last of the la	States of S	A STATE	San San San San San San San San San San					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Mary Bridget Kane /Medical Dec. 2004 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Havre de Grace

If Under 1 Year | If Under 24 Hrs.

Months Days | Hours | Min. Harford Memorial Hospital Harford 5. Social Security Number 8. Date of Birth (Month, Day, Year) 06/11/1944 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Yrs. 60 Director 026-32-8567 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "naturel", or items 23a or 28a-1 ehow other traumatic event, it at Medical Exactivar must be notified at Director MD Harford <u>Havre de Grace</u> 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 920 Hebditch Lane Funeral 21078 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. It and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Logistics Technician U.S. Government and 2 should be file ent of Health and Mental Hys. t: If item 27 is mark or rest 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Emmanuel Salamanca Rafaela Mogavero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald G. Kane- Husband 920 Hebditch Lane, Havre de Grace, MD 21078 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 N Burial 2 □ Cremation 3 □ Removal from State ö permit. Page Department (Importent: If any injury or once. 4 Donation 5 Dother (Specify) Harford Mem. Grdns. 12/30/04 Aberdeen, MD Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MULTIPLE **Physician** ImBolin on Monay /Medical Due to (or as a consequence of): Examiner Upin if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): physician at s the burial-t 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 💇 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2. No 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3. Union NAR 601. Corol 32. Registrar's Signature State

42605

3. Time of Death

2:00a

10d. Inside City Limits

MD 21078

Approximate Interval Between Onset and Death

Year

Day

1 Yes 2 No

Registrar DHMH 17 Rev 1/2001

				1- State of Maryland / Department of H Registrar Certificate of L	leaith and iv Death		ene2 () () 4	42606			
		Physici		1. Decedent's Name (First, Middle, Last) Ronald Kernodle		2. Date of Death Month December	n Day r 28, 2004	3. Time of Death 3:10 AM M			
		/Medio Examin		4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice 4b. City, Town, or Balti	r Location of Death		4c. County of Deat				
		Funeral Director		5. Social Security Number 231-42-5937 6. Sex 1 M 2 F 6. Sex 6.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 25,	Year) 9. Birti Co 1936 Sout	nplace (State or Foreign untry) h Carolina			
		land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
		Ba-f sh	ector	MD Baltimore				1∑Yes 2□No			
		deeth with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number 10f. Zip Code 838 N. Eutaw Street	21201	10	g. Citizen of What Co USA	untry?			
		ltams ?	uner	11. Marital Status UNK 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	ncan Indian, e, etc.			
	3036	ours aft	by	1 Never Married 2 Married 1 Yes 2 No unk If Yes, Give Year or Dates:	Specify:		Specify:	white			
	Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Itams 23a or 28a-f show any injury or other treumatic event, If a Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ation du <i>ri</i> ng most of worki d)	in <i>g</i>	6b. Kind of Business/l	^{ndustry} unk			
	1212	iled with Hygiene ther the	Com	unk unk electricia		/First Adjuste A					
	lanc	uld be fi Aental F rrked ot tic ever	To Be	17. Father's Name (First, Middle, Last) unk	18. Mother's Name) (FIFST, MIDDIN, M	aiden Sumame)	unk			
	Mary	d 2 sho th and h 7 is ma		19a. Informant's Name/Relationship (Type, Print) Joseph Richey Hospice 19b. Mailing Address (Street a							
Z		es 1 an of Heel f Item 2 r other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State			re, MD 212 Oc. Location - City or				
3:10 AM	Baltimore,	ift. Pagardment ortent: b njury o		`4 □Donation 5 🖄 Other (Specify) in state	ss of Equility						
3:1	Ba	Departiment of the particular		State Anat Baltimore,	omy Board MD 2120	655 W.	Baltimore	Street			
				23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final		r respiratory arre	st,	Approximate Interval Between Onset and Death			
	7	/Medical		Immediate Cause (Final disease or condition resulting in death) a.	Cer			Sept 2004			
7		Examiner	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
0/8		and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c							
12/28/04	68760,	tificate be executed g physicien and as the burial-transit	ledical E	d.							
1		certifica Iding ph	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Date of dall				
DLE	.O. Box	that the death cert led by the attendin detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1			23d. Date of deliver Month	Day Year			
NO	Records, P.	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.		acco use contribute to	the cause of death?			
KER		The taw rate has be page 2 sh	Completed			24a. Was an autopsy perform	ed? prior to co	opsy findings available ompletion of cause of			
1	Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	26. Place of Death			klide .			
720	ion of	ding After fune	atlon; T	1 Yes 2 Mo							
NOV	Division	To the Hospital or Attent within 24 hours efter deatl To the Funerel Director: completely filled in by the	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	28f. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,			
×		e Hospi 24 hou e Funer etely fill.	dical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time of the basis of examination and/or investigation, in my operand manner stated.	ne, date and place, a pinion, death occurre	and due to the cau	ise(s) and manner as a e and place, and due	stated. to the cause(s)			
		To th within To th compl	Me	29b. Signal eand title of certifier 29c. License	number	290	d. Date signed (Month,	Day, Year)			
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	06030	MO	Dee 2	8,2064			
				DAVID LIKNOX, QW. hoke AVE, 7	3eltmon	e his	2/210-1	303			
		Sta Registr		31. Date filod (Month, Day, Year) 82. Registrar's Signature							

State of Maryland / Department of Health and Mental Hygien 42607 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician Edith November 2004 6:20 A /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Potomac Valley Nursing Home Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M XXF Director 79 May 18, 1925 362-28-9318 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28e-f show the Medical Examinar must be notified at 1 Yes 2 □ No Directo Maryland | Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 1235 Potomac Valley Dr. 20850 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiens important: if item 27 is marked other than "na any injury or other treumatic event, the Madic once. Elementary/Secondary (0-12) College (1-4or 5+) 12 N/AN/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be N/A N/A 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Karen Miller/Attorney 1001 Connecticut Ave. NW #1137 Washington, DC 20036 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 11/15/2004 Rockville,MD Menorah Gardens 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility Hines-Rinaldi F.H. 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. First. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, minds, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Imona dia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Erries Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 7No Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After t or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 038262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Research BLUD MEN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 1 2005 Registrar

B.K.S FRANCES LANSDALE

	1	For State of Maryland / Departmen **Registrar** State of Maryland / Departmen **Certification **Certification **The control of the contr	te of Death			1,200
Physician	ŧ	1. Decedent's Name (First, Middle, Last) Frances Lansdale		2. Date of Death	A C	3. Time or beath
/Medical Examiner		WASHINGTON ADVENTIST HOSPITAL T	Town, or Location of Death AKOMA PARK r 1 Year If Under 24 Hrs.		4c. County of Death	Y
Funeral Director		5. Social Security Number UNK 6. Sex 1 M M 2 F 7. Age (In yrs. last birthday) If Unde 83 Yrs. Months Usual Residence of Decedent		8. Date of Birth (Month, Day,) Dec 11,	1921 9. Birth	place (State or Foreigntry) unk
f show lied at		10a. State 10b. County 10c. City, Town or Location MD Prince George's Hyattsville				10d. Inside City Limit
death with the Maryland the 23s or 28s-1 show thoust to multiled at	3	10e. Street and Number 10f. Zij	20785	10	g. Citizen of What Cou USA	intry?
urs after death with the Mar all, or Itams 23a or 28a-f si xunding ust to notified by Funeral Director			dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
2 should be lined within 72 hours after death with the Marylar Mohald Hygiene. is marked other than "natural", or Itams 23a or 28a-f show aumstic event, thu Mohald Examinational to multiple at To Be Completed by Funeral Director	navaidino 1	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk 16a. Decedent's Usu (Give kind of we life. DO NOT u	al Occupation rk done during most of work se retired)	ing unk 16	6b. Kind of Business/Ir	ndustry u
Mental Hyg Mental Hyg arkad otha atic evant, To Be C	3		unk 18. Mother's Nam	e (First, Middle, Ma	aiden Surname)	uı
0 £ ~ =			s (Street and Number or Run n Street Balt			p Code)
Page national nry or	2	20a. Method of Disposition 1	me of		Oc. Location - City or T	own, State
Departm Departm Imports any Inju		21. Signature of Euroral Service Licensee Ronal d S. Way, Director State Baltim	Anatomy Board Ore, MD 2120	1 655 W.	Baltimore	Street
physician and he purial-transit the purial-transit aminer		Immediate Cause (Final disease or condition resulting in death) a. Attoroscle. At Due to (or as a consequence of): b. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. d.	zivovas culo	s Dife	aje	Onset and Death
gned by the attending plue detached for use as the detached for use and the detached for use at the de	0	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic properties of the pregnant at time of death 5 ☐ Other (sp. 9 ☐ Unknown)		100000	23d. Date of delive	ery Day Year
		Part II. Other significant conditions contributing to death but not resulting in the underlying o	ause given in Part I.		cco use contribute to t	he cause of death? pably 4 💋 nknov
W - ()	_			24a. Was an autopsy performe	d? death?	opsy findings availab impletion of cause of 2 No
His Pile	2	25. Was case referred to medical examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2X ER/Outpatient 3 DC 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending	Other: 4 Nursing Ho	me 5 Residence 28d. Describe how	ce 6 □Other (Specif	(y)
o within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Medical Certification:		2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined 28e. Place of Injury At home, farm, street, factor building, etc. (Specify)	28f. Location (Stre City or Town, :	if. Location (Street and Number or Rural Route Number, City or Town, State)		
thin 24 hours thin 24 hours the Funeral mpletely filled		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	at the time, date and place, , in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as s a and place, and due to	tated. the cause(s)
To the comp	2	29b. Signature and title of certifier 29c	O.C.M.E		DEC. 20,	
	3	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO, HD 111 PFNN STRF	DATE DATE OF	NADSZI ANI	D 01001	
		31. Date filed (Month AN Year) 1 2005 32. Jegistrar's Signature	ET, BALTIMORE	J, MARYLAN	D ZIZOI	

			For Amend I	[tem	State of 23a pe	of Man	yland / ₉ l	Depa 'Cei	artmen	of H	ealth a	and M	lental Hy	giene Reg. No.	2001	4 42	600
			Decedent's Name (First, M.					-					2. Date of De		Yeer	3. Time o	f Death
	Physicia /Medic		Eugene Morr	is									Novemb		2004	7:01	PM ^M
	Examin		4a. Facility Name (If not instit			ımber)					Location of				unty of Deet		
4			1001 Salem 5. Social Security Number U			7 100 //	n yrs. last bii	thday)	If Under		s town		9 Date of Bir		ashin	gton thplece (State	or Forming
	Funeral Director		5. Social Security Number (L)		MM 2□F		11 yrs. 1431 bii 31	Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da Feb 22	iy, Year) 1923	9. BIN	ountry)	unk
			Usual Residence of Deceden	t			, _		1				100 22	, 1723			
	nylan ihow		10a. State 10b. Co	•	- t	10	Oc. City, Tow			_						10d. Inside C	
	Ba-1 e	Director		shin	gton 		н	age	rstow								2∕\ No
	vith th	2	10e. Street and Number						10f. Zip					10g. Citizer	of What Co	ountry?	
	s 23c	eral	1001 Salem A		e 12. Was Dec	andent Eve	rinlls	12 1	Was Doord		21740		oity Vas or No		USA Bace - Ame	erican Indian,	
	ther d	Funeral	11. Marital Status 1 □ Never Married 2 □	unk Married	Armed F		unk	1			n, Mexican	n, Puerto	ecify Yes or No Rican, etc.)		Black, White		
200	hours after death with the Maryland turel; or Items 23e or 28e-f show at Expedimental be notified at	b	3 Widowed 4 Divo		If Yes, G Year or	ive			1□Yes 2	No No	Specify:			Sp	ecity: W	hite	
21215-0036	I within 72 hours after death with the Marylan jiene. Iten, "naturel", or items 23e or 28e-f show the Modical Exertitive at the Modical Exertitive a	Completed	15. Dece (Specify only hi	edent's Ed	ducation ade completed)	16a	(Give	dent's Usua kind of wor	k done a	turing mos.	t of workii	ng unk	16b. Kind	of Business/	/Industry	unk
7	within 72 ene. than "nai ne Madic	du	Elementary/Secondary (0-	12)	College	(1-4or 5+)		life.	DO NOT us	e retired,)						
	filed w Hygier other ti		unk 17. Father's Name (First, Mid		unk					ınk	18 Mothe	ar's Namo	(First, Middle	Maiden Su			unk
and	a la b) Be	17. Patrol 3 Name (1 //34, 1860	DIO, EUSI,							10. 11101110	JI S IVAIIIO	(mat, made	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	marro,		unk
Maryland	s 1 and 2 should be t f Health and Mental I ftem 27 is marked o other traumatic eve	2	19a. Informant's Name/Relat	ionship (Type, Print)		198	. Mailir	ng Address	(Street a	and Numbe	er or Rura	I Route Numb	er, City or To	own, State, 2	Zip Code)	unle
	1 and 2: Health ar Iom 27 is		Joyce Willia	ns/F	Ι												unk
Je,	of Hee		20a. Method of Disposition		30		20b. Place o	f Dispo	sition (Nam	ne of ther place	a)	D	ate	20c. Locat	ion - City or	Town, State	
Ĕ	Pages nent of I int: If It iny or o		1 ☐ Burial 2 ☐ Cremat 1 ☐ Donation 5 🖾 Other	er (Specif) in st			,	ŕ		t t						
Baltimore,	permit. Pages Department of I Important: If It any Injury or o		21 nature of Euneral or ROMA I	vice Licer	X249.	y gc	tor	Si Ba	Name an tate A altimo	d Addres	s of Facilit Omy B	oard	655 W.	Balt:	imore	Street	
	- 1		23a Part 1. Enter the diseas	e, or com	plications that	caused the	e death. Do	_								Approxima	te
	Physician		shock, or heart failure. Immediate Cause (Final	List only	one cause on	each line.		/ .			L-					Onset and	Death
	/Medical		disease or condition resulting in death)	-	a. Due to	o (or as e co	onsequence		c	11/	615					s min	181
	Examiner		Sequentially list conditions,	- 1	b		Recta	11 (Cancer	•							
	р <u>;</u>	iner	if any, leading to immediate cause. Enter Underlying	1	Due to	(or as a co	c isaquenca	of).									
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		c. Due to	loras a ci	onsequence	of):							_		
760,	ate be executed nysician and he burial-transit	calE		ı		(5, 25 2 5	01.334331103	51/.									
	ficate phys s the	_			_ d												
Вох	death certificat e attending phy d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnan	t I	23c. If yes, or				-					23d	. Date of del	ivery	
	death e atte	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No		4☐ Preg	nant at tim	Fetal death		Ectopic pr Other (sp						Month	Day	Year
o.	at the de by the a stached f	hys	9 🗆 Unknown	ļ	9□ Unk												
	law requires that the as been signed by th 2 should be detache	by F	Part II. Other significant cor	ditions	contributing to	death but n	not resulting	n the u	nderlying c	ause give	en in Part I.				/	the cause of	
ord	v require been sig should b	Completed											1	Yes 2 M	10 3 LI PI	obably 4 🗆	UNKNOWN
Vital Records,	e 2 sl	nple											24a. Was		4b. Were au prior to death?	itopsy findings completion of c	available cause of
<u>=</u>	icien: The lav certilicate has rector, page 2 :												1 ☐ Yes	2 12 No		2□ No	
=======================================	Physicien: r this certific ral director.	Be	25. Was case referred to me examiner? 1 Yes 2 No	dical	Hospital:	Inpatient	2 🗆 ER/O			Othe			n <i>(Check only o</i> me 5⊡ Resi		10:5 - 70	7.	
ō	Attending Physicien: r death. ector: After this certific by the funeral director.); To	27. Manner of Death			of Injury of, Day Yo		Time o	_	8c. Injury Work	at at		ne 5 G Hesi 28d. Describe			спу)	
ion	nding lth. r: Afte e fun	atlo	1 ☐ Natural 5 ☐ Pe	ending vestigatio		ntn, Day Y	ear)	Injury	М		<br Yes 2□	No					
Division of	er des recto by th	Certification;		ould not b termined	289. Plac	e of Injury ding, etc. (- At home, fa	arm, str	reet, factory	, office		1	28f. Location (City or To		umber or Ru	ıral Route Nun	nber,
	ital o irs aft ral Di																
	To the Hospital or Attending 6 within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Cert (Check only 2 Med	ifying Pl	nysician: To the miner: On the and ma	ne best of n basis of ex nner stated	amination as	e, deat nd/or in	h occurred vestigation	at the tim in my of	ne, date an pinion, dea	id place, a ith occurre	and due to the ed at the time,	cause(s) and date and pla	d manner as ice, and due	stated. to the cause(s)
	within To the	Me	29b. Signature and title of ce	rtifier	4				290	. License	number			29d. Date s	gned (Monti	h, Day, Year)	
)			Much		1. M					00	1166	7			. 2 . 0		
	12		30. Name and address of pe	rson who	completed car	use of deat	th (Item 23a)	(Туре,	Print)			,			/ #		
	'		31. Date filed (Month, Day,)	(025)	16601	Macco	Sinnatura	111	110	M	edica	c/ ((mys	v2 6	Pegar	yloun	m
586	Sta Registi		JAN 1 0	2005	completed car	L S	Signature	est.									

DHMH 17 Rev 1/2001

ORIGINAL

Matthews, Bernice

			1 - For State Registrar	State of Ma	ryland / Depa	artment of F		-	giene Reg. No. 201	16 1,2611
	B1		1. Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Time of Death
	Physici /Medio		BRENDA SUE	MEI	LE			DECEMBE		
	Examir		4a. Fecility Name (If not institution, give s	street and number)		4b. City, Town, o		ath	4c. County of D	eath
			HARBOR HOSPITAL				IMORE		NIA	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	Hours Mi	n. (Month. Da	v. Year)	Birthplace (State or Foreign Country)
	Director		217-56-2096 Usual Residence of Decedent		51 Yrs.			March	03, 1953 W	est Virginia
	/land		10a. State 10b. County		10c. City, Town or Lo	cation				10d. tnside City Limits
	Man	ţō	Maryland Baltimore		Halethor	ne				1 ☐ Yes ŽŽNo
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	
	th wil	aiD	1702 Arbutus Avenu	e		21227		Į	United Sta of America	ites
	ems efin	Funeral	· · · · · · · · · · · · · · · · · · ·	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or No- erto Rican, etc.)		merican tndian,
36	or It		1 Never Married Married	Armed Forces? 1 ☐ Yes 2 2 2 10 If Yes, Give	0	1 □ Yes XXNo		, , , , , , , , , , , , , , , , , , , ,	Specify:	Titto, oto.
8	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jisal Evandiver investe profith of at	d by	3 Widowed 4 Divorced	Year or Dates:	10- 0				W	hite
21215-0036	- 104	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w	rorking	16b. Kind of Busine	ss/Industry
12	filed within Hygiene. Ither than "	mc	Elementary/Secondary (0-12)	Coltege (1-4or 5	+)	ministrat			Funeral S	ervice
b	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or Items 23s or 28s-f show event, the Medical Evanding for notified in	BeC	17. Father's Name (First, Middle, Last)				T	ame (First, Middle,		CIVICC
<u>a</u>	should be filed within the Mental Hygiene. marked other than imatic event, the Mental th		Hugh Alton Loy				Flora M	ay Hood		
Maryland	2 should be fi and Mental H Is marked of aumatic ever	Γ.	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street	and Number or I	Rural Route Numbe	er, City or Town, State	e, Zip Code)
	as 1 and 2 should of Health and Men I Item 27 Is marker other traumatic		Charles Howard Mei	le (Husba			Avenue;	Halethor	rpe, Maryl	and 21227
Baltimore,			20a. Method of Disposition YXBurial 2 □ Cremation 3 □ R	emoval from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other place	ce) Int	Date 6	20c. Location - City	or Town, State
Ĕ	permit. Pages Department of I Important: If Its any injury or of		'4 □ Donation 5 □ Other (Specify)		Loudon Pa	rk Cemet	erv 200	nuary 6,	Baltimore,	Maryland
3alt	permit. Pag Department Important: any injury once.		21. Si mature of Funeral Service License	1016/	22	. Name and Addre	ss of FacilityLo	udon Parl 20 Wilker	k Funeral is Avenue Maryland	Home
	70 = 4 O		711101011	and.						
			23a. Park Enter the disease, or compli shock, or heart failure. List only or	cations that caused le cause on each lin	the death. Do not ent e.	er the mode of dyir	ng, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		tmhediate Cause (Final disease or condition resulting in death)	Liven	foilur consequence of):					~ weak
	Examiner									
		ē	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a	tatic b	reast c	cancer			~> years
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	be executed sician and burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medicai		l						
9	ing ph	Med	IF FEMALE:							
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	2 ☐ Fetal death 3 ☐	Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
0.	t the dea by the a tached for	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Winknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify)	-		WOTE	Day Teal
Δ.	that the		Part II. Other significant conditions con	tributing to death bu	t not resulting in the u	nderlying cause giv	ren in Part I	23e. Did to	phacco use contribute	to the cause of death?
of Vital Records,	sign sign d be	d by		3		,				Probably 4 □Unknown
Sor	w require been si should I	ete						24a. Was a	20 24h Wara	autopsy findings available
Re	The lav ate has page 2	Completed						autop perfor	sy prior death	to completion of cause of
ta		Ö	25. Was case referred to medical				36 Place of D	1 ☐ Yes eath (Check only or	2 No 1 Y	es 2 No
<u>></u>	Physician: this certific ral director,	o B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatier	nt 2 ER/Outpatien	t 3 DOA Oth			lence 6 Other (S	pecify)
0	ding Ph h. After th funeral	T ; U	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time of	28c. Injun Worl			low injury occurred	,,
joi	Attending r death. ector: After by the funer	atic	1 ☑ Natural 5 ☐ Pending investigation	(,,		Yes 2 □ No			
Division	ial or Attendii s after death. al Director: A ed in by the fu	Certifications	3 Suicide 6 Could not be determined	28e. Ptace of Inju building, etc	ry - At home, farm, str. . (Specify)	eet, factory, office		28f. Location (S City or Tow	Street and Number or m, State)	Rural Route Number,
	spital or ours afte seral Dir filled in			1				1		
	Hosp 24 hol Fune Fune	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ner: On the basis of	f my knowledge, death examination and/or in-	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	ce, and due to the courred at the time, or	cause(s) and manner date and place, and c	as stated. ue to the cause(s)
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	Mec	29b. Signature and title of certifier	and manner sta		29c. Licens	e number	2	29d. Date signed (Mo	enth, Day, Year)
	⊢ s ⊢ ō		Katheson St en	Lais, M.D.	(intern	RE	5000		ECEMBER	
	1		30. Name and address of person who co							
	Ą			2id n	2421 K	nappsh	Jay (Odenton	MD 211	13
	Sta		31. Date filed (Month, Day, Year)	32. Begistra	ath (Item 23a) (Type, 2 4 2 1 K r's Signature	ً فد ا		:		
	Registr	ar	JAN 1 0 20	105 Block	w St A	2042				

			1 - For State of Maryla		artment of Health and N tificate of Death	Reg	ene 1. No. 2001	1.2010
F	Physicia	an	Decedent's Name (First, Middle, Last)	Matthor		2, Date of Death Month	Day Year	3. Time_of Death
	/Medic	al	Doris S. 4a. Facility Name (If not institution, give street and number)	Matthew	4b. City, Town, or Location of Death	December		
	Examin	er	Ci Hi il DO Hi.	16	Baltimore City		4c. County of Deat	л
	Funeral		5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9. Birt	hplace (State or Foreign untry)
	Director		217 20 3037	75 Yrs.	Months Days Hours Min.	7-15-1	929	Md Md
	and		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	cation			10d. Inside City Limits
	Maryl f sho	tor		llicott				1 ☐ Yes 2 No
	r 28a	irec	10e. Street and Number		10f. Zip Code	100	. Citizen of What Co	untry?
	th wit	ai D	8700 Ridge Road		21043		U S A	200
980	permit. Pages 1 end 2 should ba filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23s or 28s-f show any Injury or othar traumatic event. The Medical Exartition must be inclined at ORDS.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	li li	Nas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto I ☐ Yes 2☐xNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: B	
2-0	72 hc natur	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during most of work	ina 16	6b. Kind of Business/	ndustry
21215-0036	d within giene. ir than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 1 year	life. L	ial Worker		Urban Ser	vice Agency
Maryland	d ba file antal Hyg red othe c event.	Be	17. Father's Name (First, Middle, Last) Amos Smith		18. Mother's Name Viola Be	e (First, Middle, Ma	iden Sumame)	
ary.	shoul nd Me mark umati	J.	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number or Run		City or Town, State, Z	lip Code)
	and 2 aith a 27 is		Charles Matthews - Son	532	S. Beechfield Av	enue Bal	to, Md 21	229
Baltimore,	Pages 1 oment of He ent: If Item ury or oth		MTPurial 2 Comption 2 Pamoual from State	cemetery, crem topkins	sition (Name of natory or other place) United Meth 1-7-		c. Location - City or ghland, M	
Balt	permit. Depart Import any inj		21. Sign to e of Funeral Service Licensee		4300 Wabash Av	enue Balt		15
	Physician		23a. Parti. Enter the disease, or complications that caused the deshock, or heart value. List only one cause on each line. Immediate Cause (Final disease or condition	. 00	er the mode of dying, such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death
	/Medical		resulting in death) Due to (or as a cons		10 2 (0xC2			10 days
	Examiner		Sequentially list conditions, b. Atherosci	erstic h	eart disease			10 years
	ed sit	nine	Sequentially list conditions, Tany leading to minediate cause. Enter Underlying Cause (Disease or injury	aquanna of)-				U
	death certificate ba executed e attending physicien and id for use as the burial-transit	Examiner	that initiated events c. Due to (or as a cons	equence of):				
8760,	se ba	cail	d					
9		Medi	IF FEMALE:	-				
Вох	res that the death certificing of the attending for the detached for use as	Physician/Medical	23b. Was decedent pregnant 23c. If yes, outcome of pregnant 1 Live birth 2 Feb.	etal death 3 🗌	Ectopic pregnancy		23d. Date of deli	very Day Year
0	the a	ysic	1 Yes 2 No 4 Pregnant at time o	łdeath 5□	Other (specify)		TWO TEST	Day
<u>α</u>	The law requires that the ate hes been signed by the bage 2 should be detached.	V Ph	Part II. Other significant conditions contributing to death but not a	esulting in the ur	iderlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
rds,	quires in sign	Completed by	Congestive heart failure			1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Donknown
Vital Record	aw requir is been si 2 should	piet	O			24a. Was an	24b. Were aut	topsy findings available
Ä		Com				autopsy performe 1 ☐ Yes 2 €	d? death? INo 1 ☐ Yes	ompletion of cause of
/ita	lcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			(Check only one)		
of/	S S S	70		☐ ER/Outpatient			e 6 Other (Spec	ify)
no	ding h. h. After funer	tlon	27. Manner of Death 1 PNatural 5 Pending (Month, Day Year,	28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division of	Attandi r death. ctor: A by the fu	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - Al	home, farm, stre		28f. Location (Stree	et and Number or Rui	ral Route Number,
á	s efter s efter al Dire	Certification:	4 Homicide building, etc. (Spe	cify)		City or Town, S	State)	
	To the Hospital or Attanding Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my keep one to the basis of examiner: On the basis of examiner and manner stated.	nowledge, death nation and/or inv	occurred at the time, date and place, restigation, in my opinion, death occurr	and due to the caus ed at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month	Day, Year)
}			Michael Gerdyn D.O.		RES-600	De	cember 31	12004
1	0		30. Name and address of person who complete Gause of death (II Michael Gardyn, D.O., Sin	em 23a) (Type, 1	Print) pital of Raltimo	re		
	Sta Registr		Michael Gardyn, D.O. Sin 31. Date filed (Month, Day, Year) 32. Registrare Sig JAN 07 2005	nature	1 4			
	- registr	গা	JAN U 1 2005 200	ever So	Market !			

			1 - For State Registrar		Marylan		artmen tificate			and M		Reg. No.	201	04	4261
	Physici /Medio		Decedent's Name (First, Midd Agnes	Marie		McC	Conne :	11			2. Date of December), 20°C	ar)4	3. Time of Death 8:40am M
	Examir		4a. Facility Name (If not institution	n, give street and numb	er)		4b. City,	Town, or	Location o	of Death			County of D		
		-	1001 Carroll				If I today		deric				Frede		
ı	Funeral Director		5. Social Security Number 218-14-0787	6. Sex 7. 1 ☐ M 2 X F	81	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birt	y, Y 1 392	2.3	Birthpla Countr	ice (State or Foreign Fyland
	and		Usual Residence of Decedent 10a. State 10b. County	,	10c. Cit	y, Town or Lo	cation							100	d. Inside City Limits
	ith the Marylar or 28a-f show	ector		rederick					ederi	.ck					1 XYes 2 ☐ No
	23a or 2	Funeral Director	10e. Street and Number 1001 Carroll F	arkway, Apt	T-1	2	10f. Zip	Code 2	1701			10g. Citiz	en of What U	·S.	у? А.
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If itiam 27 is marked other than "natural", or itams 23a or 28a-1 show or other traumatic avant, the Medical Examinate matter instititual at	by	11. Marital Status Never Married 2 Mar Widowed 4 Divorced	If Yes, Give	s? TaNo	'	Vas Deced f Yes, spec I□Yes		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		4. Race - A Black, W Specify:		tc.
21215-0	vithin 72 ho ne. han *natu	Completed		nt's Education st grade completed) College (1-4c	or 5+)	16a. Deced (Give life. I	kind ol wol DO NOT us	rk done d se retired,	luring most)				d of Busine		•
land 2	id be filed v ental Hygie kad othar t ic avant, Ib	To Be Co	17. Father's Name (First, Middle, John Robert		Sr.	OLCLE		Ficili	18. Mothe	r's Name	(First, Middle, Gallery	Maiden S		VELI	
, Maryland	1 and 2 shou Health and M tam 27 is mar other traumati		19a. Informant's Name/Relation: Leo Michael Te			4212	Mano	rwoo	d Dri	ve,	Glen Ar				Code)
Baltimore,	Pa		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3)		II D	Place of Dispo cemetery, crem Olive1					29, 200		reder		n, State • Mary land
Balt	permit. Pag Department Important: I any injury o		21. Son ature of Funeral Service	Licensee May	and						Funeral eet, Fr			MD 1	21701
	Physician		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause on each	n line.	n. Do not ent	er the mode	e of dying	g, such as	cardiac o	r respiratory ar	rest,		l A	Approximate on terval Between Conset and Death Year's
	/Medical Examiner			b	as a conseq							_			
,	cate be executed only sician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S c	as a conseq										
68760,	ficate be p physicial ts the buri	dical		d											
P.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩ No 9 □ Unknown	23c. If yes, outcor 1 □Live birth 4 □ Pregnan 9 □ Unknowr	2 Feta t at time of d	Ideath 3	Ectopic pro Other (spe					23	Bd. Date of o		ay Year
Ś	w requires that the been signed by th should be detache	by	Part II. Other significant conditi	ons contributing to death	but not res	ulting in the ur	derlying ca	ause give	n in Part I.		23e. Did to				cause of death?
Il Record	The law ate has b page 2 s	Completed			-				· · ·		24a. Was a autop: perfor 1 Tyes	sy	24b. Were prior to death	o comp	y findings available pletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:				Otho			Check onl or				
of	ding h. After fune	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi 2 Accident invest	28a. Date of I		ER/Outpatien 28b. Time of Injury		8c. Injury Work	at	2	ne 5 Resid			oecify)	
Division	or in Dir	Certification:	3 Suicide 6 Could determ	nined 286. Place of	Injury - At he etc. <i>(Specif</i>	ome, farm, stre	eet, factory	, office		2	28f. Location (S City or Tow	treet and n, State)	Number or	Rural F	Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one)	ng Physician: To the be Examiner On the bisis and manner	of examina	wledge, death tion and/or inv	occurred a restigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the co	ause(s) a date and p	nd manner lace, and d	as state	ed. ne cause(s)
	To t Withi To tl	Ž	29b. Signature and title of pertine	er .			29c	. License					signed (Mo		
•	101		Y	MI J				D31	912		I	Jecen	ber 2	ω,	2004
/	18		30. Name and address of person			23 <i>a</i>) (Type, I		le c	Even al		. M_ 14-1	الصما	21702	/ 2	50
	Sta	ite	Julia Menocal 31. Date filed (Month, Pay, Year,	L, M.D., 130	04 UNO strar's Sigga	SSUMTO	W∏ Pl	ke,	rrede	erick	, Mary.	Land	21/02	-43	59
1	Registr	-	JAN V /	ZUUD JOHN	A 18 8 2	ture	S. S. S. S. S. S. S. S. S. S. S. S. S. S								

			1 - For Unpersonal State Unpersonal Stat	end Item	State of Ma 23a,27,28a	aryland / D	epartmer Le G840 Certifica	nt of Hea	Ith and No. tas	Mental H	ygiene	2004	1.2611
	g -			e (First, Middle, Las					4177	2. Date of D	eath		3. Time of Death
	Physic /Medi		Angela N							Decemb	er 30,	2004	11:50 A M
	Exami	ner	4a. Facility Name (II 801 E. 30	fnot institution, give Oth Stree	street and number)			Town, or Loc timore	ation of Death		4c. C	ounty of Oeath N/A	
Ô	Funeral Director		5. Social Security N 212-76-8	3761	9x 7. Age □ M 2 🛣 F	(In yrs. last birth	Months		Under 24 Hrs. ours Min.	8. Date of B (Month, D		9. Birth Cou MD	place (State or Foreign ntry)
,	land		Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town	or Location						10d Inside City I Inside
	Marylan -f show lied at	ţō	MD			Baltimo							10d, Inside City Limits 1 ☐ Yes 2 ☐ No
	h the	Director	10e. Street and Nun	nber		Darcin		p Code			10g. Citize	n of What Cou	
	23a c	a	801 E. 3	30th St.			21	202			USA		•
36	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or Items 23a or 28a-1 show event, the Modical Exartine must be notified at	by Funeral	11. Marital Status	ed 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		13. Was Dece If Yes, spe 1 \(\text{Yes} \)	.32	nic Origin? (Sp exican, Puerto pecify:	ecify Yes or N Rican, etc.)	lo- 14.	Race - Americ Black, White,	etc.
8	2 hou	ted		15. Decedent's Edi	ucation	16a, D	ecedent's Usu	al Occupation			,	of Business/în	
215	thin 7. e. an "n	Completed	(Speci	ify only highest grad	de completed) College (1-4or 5-		Give kind of wo ife. DO NOT u	ork done during se retired)	g most of work	ing	TOD. KING	or business/in	dustry
21	filed with Hygiene. other than	Con	12th			,	sing				Hosp	ital	
and	be fill hall Hall Hall Hall Hall Hall Hall Ha	Be	17. Father's Name (Mother's Name			ımame)	
ž	2 should be filed within and Mental Hygiene. 1s marked other than raumatic evant, Ite M	٩	Donald M	lyers me/Relationship <i>(T</i>	ivos Printl	105.1	4-16 4-4-1	,	illian				
Baltimore, Maryland 21215-0036	D =		Donald M	Myers (b	•	142	21 Mon	tepel:	ier Ba	lto.	MD 21		
20	permit. Pages 1 am Department of Heal Important: If item 2 any injury or other once.			☐Cremation 3 ☐F	Removal from State	20b. Place of D cemetery,		me of other place)	i	Date		tion - City or To	
Ħ	artme artme ortant injury	ŀ	* 4 ☐ Donation 21. Signature of Sur	5 Other (Specify,		Mt. Ca		nd Address of I	1-7-			lk, Mi	
Ba	permit. Departri Importe any inju) W	esleur	Marit		2007	Easte	rn Ave	ley C	havis to. M	Jr. 1	FH 31
			23a. Part1. Enter the shock, or hear	e disease r comp t failur List only o	lications that coused to ne cause or each line	he death. Do no							Approximate Interval Between
	Physician /Medical		Immediate Cause (I disease or condition resulting in death)	Final	Venlafax								Onset and Death
	cate be executed XX physician and ithe burial-transit and	dicai Examiner	Sequentially list con if any, leading to imicause. Enter Under Cause (Disease on in that initiated events resulting in death) L	njury	b. Due to (or as a	consequence of) consequence of)	:						
Box 6	death certifii e attending p id for use as	Physiclan/Medi	IF FEMALE: 23b. Was decedent in the past 12 r 1 yes 2 yes 9 Yunknown	nonths?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death	3 ☐ Ectopic pr 5 ☐ Other (sp				23d.	. Date of delive Month	ry Day Year
s, P	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other signific	cant conditions co	ntributing to death but	not resulting in th	e underlying c	ause given in F	Part I.	23e. Did 1	obacco use	contribute to th	e cause of death?
ord	w require been sig should b	ted t								10	Yes 200	o 3 Proba	ably 4 Unknown
<u>د</u>	The ate h page	Completed			-					24a. Was auto perfo	an 24 psy prmed? 2□No	death	osy findings available appletion of cause of
	Physician: this certific ral director,	o Be	25. Was case referre examiner? 1 Yes 2 N	1 4	Hospital:	2 C E B/O-1		0.1	Place of Death				
Division of	F = E	tlon: To	27. Manner of Death	5 Pending investigation	28a. Date of Injury Found	2 ER/Outpa 28b. Tim Four	e of 2	8c. Injury at Work?		1e 5 Resi 8d. Describe		curred	at scene nk
Visi	Hospital or Attanding I 24 hours after death. Funeral Diractor: After tely filled in by the funer	Certification:	2 Accident 3 Suicide 4 Homicide	6 X Could not be determined	12-30-04 28e. Place of Injury building, etc.	11:3	UA		X No 2	8f. Location (Street and No	umber or Rural	Route Number,
	ris after ral Dira lled in by				Found at	home				partimo	ore, mo	1	Oth St.
I	lo the Hospital or Attanding within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune	edical	29a. Certifier (Check only one)	Certifying Phys Medicel Examin	sician: To the best of ner: On the basis of e and manner state	xamination and/o	eath occurred a r investigation,	at the time, dat in my opinion,	te and place, a , death occurre	nd due to the d at the time.	cause(s) and date and plac	manner as sta ce, and due to	ated. the cause(s)
	withir To th comp	Me	29b. Signature and ti	tle of certifier		4	29c	License numb	ber		29d. Date sig	gned (Month, D	Day, Year)
)	al of	·	30. Name and address	onle h	e Usul	1h (lam 232) (Tu	Do Briet)	O.C.M	.E.		Decemb	er 31,	2004
	Sta	20	MANUAD 31. Date filed (Month	LTD A.	KORELU 32. Registrar	1	11 Penr	Stree	t, Balt	imore,	Mary1	and 21:	201
3	Registr						1 4						
DHM	H 17 Rev 1/20	01		JAN 0 7 21	005 Bee		Goods	-					
						ORIGI	NAL						

StateRegistrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrer Reg. No Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year *Physician 2006 26 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner +111101-c Samaritan 05 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 24, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2 🗙 F 61 Yrs. Director 150-38-5636 Usual Residence of Decedent death with the Maryland unk 10c. City, Town or Location e filed within 72 hours after death with the Maryland at Hygiene.
other than "natural", or flems 23s or 28s-1 show vent, the Medical Evantion must be notified at 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√ No Director FLFort Lauderdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2510 Northeast Harris 33304 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) unk College (1-4or 5+) unk other traumatic evant. unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) p+mit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event unk Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Good Samaritan Hospital 5601 Loch Raven Blvd Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 🖾 Other (Specify) in 21. Signature of Funeral Service Licenses Ronald State Anatomy Board 655 W. Baltimore Street actor Baltimore, MD 21201 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Tetastatic /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and -trar Due to (or as a consequence of): the attending physician a hed for use as the burial-P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 12 No 9 Unknown 9 Unknown signed by d 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 4 DUnknown 1 ☐ Yes 2 ☐ No 3 Probably Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificate 2 No 1 Yes 2 0 No 1 Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 12 No 1 Inpatient 2 1 Tes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation М 2 Accident within 24 hours after deatl

To the Funaral Diractor:
completely filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 [Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 5000

Registrar

State

YIC 17421

31. Date filed (Month, Day, Year)

1 2005

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Kucn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4

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	Dhamia		Decedent's Name (First, Middle, Le	est)					2. Date of D Month	eath Day	V	3. Time of Death
	Physic /Medi		JANE S.	PA	RKER				DECEM	BER 31,	Year 2004	10:20PM
	Exami		4a. Facility Name (If not institution, gir		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			4b. City, Town, o	or Location of Dea		ty of Death	10.501111
	=xaiiii		8611 DUNBROOK I	I A NIE				LAUREL		DOTNI	CE GEO	DCEC
	F	_			n vrs last hirt	hday) If	Jnder 1 Year	If Under 24 H	rs. R Date of B			
н	Funeral Director			1□ M 2□XF 8	n yrs. last birt	Yrs. Mo	nths Days	Hours M	in. (Month, D	ay, Year)	Countr	ace (State or Foreign
	Director		217-16-0057 Usual Residence of Decedent						APRIL	25, 1921	MARY	LANU
	and w		10a. State 10b. County	1/	Dc. City, Town	or Locatio	n		-		10.	d. Inside City Limits
	show	٦.									100	XXYes 2□No
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	F or a	Director	10e. Street end Number			10	of. Zip Code			10g. Citizen of	Whet Country	y?
	th w 23a		6100 WESTCHESTER	PARK DRIVE	#1018		2074	0		U.S.A.		
	dea E	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U,S.	13. Was I	Decedent of H	ispanic Origin?	(Specify Yes or Nerto Rican, etc.)	o- 14. Ra	ce - Americar	
0	after or its		1 Never Married 2 Married	1 ☐ Yes 2 TNo					eπo Hican, etc.)		ck, White, et	
8	n 72 hours after death with the Maryland *netural', or items 23a or 28a-f show calicul Examiner must be redified at	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 L Y	es 21X No	Specify:		Specii	WHITE	
9	2 ho	Completed	15. Decedent's E	ducation	16a.	Decedent's	Usual Occup	ation		16b. Kind of B	lusiness/Indu	estry
21215-0020	n Z	ple	(Specify only highest gra			(Give kind life. DO N	of work done OT use retired	during most of w	orking			,
Ξ	tha ene	E	Elementary/Secondary (0-12)	College (1-4or 5+)		ROO	KKEEPE	D		AUTON	MOBILE	
Ö	filed The Hyg	Ö	17. Father's Name (First, Middle, Last		-	500	KKLLIL		ame (First, Middle			
an	ntal ed o	Be	SHERMAN H. SHOCK							, maraon barriar		
⋝	I Me I Sark	2					-	ESTHER				
Maryland	2 st and is n	0.0	19a. Informant's Name/Relationship (Rural Route Numb			∶o d e)
-	and ealth n 27 her to		JUDITH WEST/DAUGHT					OK LN.	LAUREL,	MV 20708	\$	
Ž	of H		20a. Method of Disposition		20b. Place of cemetery	Disposition /, cremator	(Neme of or other place	e)	Date	20c. Location	- City or Towr	n, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturn any injury or other traumatic event, the Medical. ance.		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	JHemoval from State fy)	BAIT -	WASH	- CREM	ATORY	1-4-05	LAUREI	MD	
፷	artm orta		21. Signature of Funeral Service Lice		D/(L)				LECK FUN	EDAI HAL	IE THE	
ä	Depa Impo any ir	ng in	1 remato	1 Wast							•	•
	0.0			- 00 00.		7601	SANDY	SPRING	RD. LAU	REL, MD	20707	
			23a. Part1. Enter the disease, or com shock, or heart allure. List only	plications that caused the one cause on each line.	death. Do no	ot enter the	mode of dyin	g, such as cerdi	ac or respiratory a	rrest,	A	pproximate ntervel Between
1	Physician	ß I									Ó	Onset and Death
1	/Medical		Immediate Cause (Finat disease or condition	ACUTE LY	MPHOBL:	ASTIC	LEUKE,	MIA			4	4 WEEKS
	Examiner		resulting in death)	a	to (or as a co	onsequenc	e of):					
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11.	ath certificate be executed tending physician and or use as the buriel-transit	Examiner	r	b.			7.0					
	exec n an	Exa	if any, leading to immediate	Due	to (or as a co	onsequence	3 OI):					
3ox 68760,	Sicia bur	ie ,	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C			-				1	_
82	phys phys the	an/Medicai	resulting in death) Last	Due	to (or as a co	onsequence	of):					
×	ding se as	ž		d							į	
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o.	The law requires thet the death ate has been signed by the atte page 2 should be detached for	Physici	Part II. Other significent conditions of	ontributing to death but no	ot resulting in t	the underly	ing cause give	en in Part I.	23b. Did	tobecco use co	ntribute to th	ne cause of deeth?
<u>.</u>	et th	£							10	Yes 2 No	3 Probat	bly 4 ☐ Unknown
Ś	as the gned be d	۵							-			
5	quire en si ould	8							24a. Was	an autopsy	24b. Were	eutopsy findings able prior to
ပ္ပ	w re	je							репо	rmed?	comp	letion of cause
ž	has ge 2	Completed										
ਰ									1 1 1	∕es 2⊠No		′es 2□ No
5	Physician: r this certific ral director,	Be	25. Was case referred to medical exeminer?	Hospitel:			011		ath (Check only o			PAUGHTER'S
5	Phys this c	ို	1 ☐ Yes 2 ☐ No	1 LI Inpatient	2 ☐ ER/Outp			ar: 4□ Nursing				RESIDENCE
Division of Vital Records, P.O	ding P. h. After t funera	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28e. Date of Injury (Month, Day Ye	er) 28b. Tir Inj	me of ury	28c. Injury Work	at	28d. Describe	now injury occurr	red	
ဇ္က	e ta :: e	ati	2 ☐ Accident investigation			М	1 🗆 \	′es 2□No				
Ĕ	al or Attend sefter death I Director: /	ij	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm	n, street, fa	ctory, office		28f. Location (S	Street and Numb	er or Rurel R	oute Number,
5	o effection	Certification:	<u></u>	building etc. (5)	pacity)				City of 10	ni, 3(6(6)		
	y fills		29a. Certifier 12 Certifying Ph	ysician: To the best of my	/ knowledge, d	death occu	rred at the tim	e, date and plac	e, end due to the	ause(s) and ma	nner as state	ed.
	To the Hospital or Atte within 24 hours efter de To the Funeral Direct completely filled in by the	edicai	(Check only one)	niner. On the basis of exe and manner stated.	mination and/	or investiga	ition, in my op	inion, death occ	urred at the time,	date and place, e	and due to the	e cause(s)
	om this	₹ P	29b. Signature and attle of certifier	1			29c. License	number		29d. Date signed	d (Month, Dei	y, Year)
	F > F 0		V/////////////////////////////////////	nilla.		-	D0875			IANUARY		
		-	1 / // ///	will						TOWNTO	J, 200	7
	15		30. Neme and address of person who									
	12		THOMAS A. BENS	SINGER M.D.	7525 (GREEN	WAY CEI	VTER DR.	#205 GF	REENBELT	, MD 2	:0770
	Sta		31. Date filed (Mg/A) (Year) 201	Registrer's S	Signature	had.	,					
	Registr	ar	- 200	The same	No. 16	Section 1	2					

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** ROBERT G. PLATO DECEMBER 28, 10:50 PM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER 8. Date of Birth (Month, Day, Year)
Jan. 18, 1934 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**√** M 2□ F Days Hours 267-44-0348 70 Yrs Director (Unknown) Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumetic average. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Completed by Funeral Directo Maryland Dorchester Cambridge 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1110 Race St. United States 21613 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZXXIo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify: Specify White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Educator University Level 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond Amos Plato Ruth ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Neese / Cousin 1110 Race St., Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Uniformed Services 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/4/05 *4 □ Donation & X Other (Specify) Bethesda, MD University 22. Name and Address of Facility Rapp Funeral and Cremation Services 21. Signature of Funeral Service Lices 933 Gist Ave., Silver Spring, MD 20910 21a Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LACTIC ACIDOSIS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Tarly, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a gonsequence of): Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ END STAGE KENAL OIS EASE 1 ☐ Yes 2 ☑ No 3 Probably 4 □Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a Wasan 1 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 Tes 2 No 2 Accident 24 hours after death a Funaral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 To tha the 29d. Date signed (Month, Day, Year) 29b. Signature and Ale of certifier onette L. Toyers, MD P18551 DECEMBER 28, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 SOUTH GREENE STREET BALTIMORE, MO 2/201 JONATHAN S. RUGERS, MO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar IAN 0 7 2005

	•	1- State Amend Item 19b per informant 6841 Certi	tment of Health and 3-21-05 tas ificate of Death	Mental Hygie	ene 2004 42619
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) 4a. Fecility Name (It not institution, give street and number)	4b. City, Town, or Location of Deat	2. Date of Death Month DOCUMBOI	Day Year 4. / JAM 4c. County of Death
Funeral Director		216-30-5785 1□M 2XJF 83 Yrs.	Baltimore If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthplace (State or Foreign Country) 1111inois
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State MD 10b. County 10c. City, Town or Local Baltimore			10d. Inside City Limits 1
sath with the s 23s or 28 must be no	eral Director	10e. Street and Number 830 W. 40th Street 11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	10f. Zip Code 21211		g. Citizen of What Country?
ours after d	by Funeral	1 Never Married 2 Married 1 Yes 2 N No	as Decedent of Hispanic Origin? (S res, specify Cuban, Mexican, Puerl Pes 2 No Specify:	o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Ind 21215-0036 be filed within 72 hours after death with the Maryland lat hygiene. In the Hygiene in attention, or items 23e or 28e-1 show event, the Medical Exercitive frost Le notified at	Completed	(Specify only highest grade completed) (Give kii	nt's Usual Occupation nd of work done during most of wor O NOT use retired)	king unk 16	sb. Kind of Business/Industry Social welfare
aryland 2 should be filed and Mental Hygi merked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Last) James Lawrence Houghteling		ne <i>(First, Middle, Ma</i> aura Delan	iden Sumame)
e, Mary 1 and 2 sho Health and em 27 is m ther traum			Address (Street and Number or Rulest End Avenue and Inc.)	22B New Y	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Exercitival for notified at		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☑ Donation 5 ☐ Other (Specify)	name and Address of Facility		
		23a. Part. Enter the disease, or complications that cadsed the death. Do not enter shock or heart failure. List only one cause on each line.	timore, MD 2120)1	
Physician /Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):			
58760, icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immorate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
I Records, P.O. Box 68 The law requires that the death certifical ate has been signed by the attending phy page 2 should be detached for use as the	by Physician/Medi		ctopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
cords, P.	ed by Pr	Part II. Other significant conditions contributing to death but not resulting in the under COY6 NAY CW fcm dis	erlying cause given in Part I.		cco use contribute to the cause of death? 2 ☑ 10 3 ☐ Probably 4 ☐ Unknown
al Record: The law requested has been page 2 should	Completed	depression		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 Section 1 Yes 2 No
Vita sician certifi rector	Be	25. Was case referred to medical examiner? 1 Yes 2 1 No 1 1 Inpatient 2 ER/Outpatient 2 1 1 1 1 1 1 1 1 1		th (Check only one)	_
	Certification: To	27. Manner of Death 1 12 Natural 5 Pending (Month, Day Year) 2 Accident 22 Accident 28a. Date of Injury (Month, Day Year)	28c. Injury at Work? M 1 Yes 2 No	ome 5 Residence 28d. Describe how	e 6 Other (Specify) injury occurred
Division (Hospital or Attending Is A hours after death. Funeral Director: After tely filled in by the funer		3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, stree building, etc. (Specify) 29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death of the street of the str		City or Town, S	
he Hos in 24 hc he Fun pletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	stigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the Ivilian 24	Σ	29b. Signature and title of certifier m ?	29c. License number D35102 .		Date signed (Month, Day, Year) ANUMY 4 2605
Sta	te_	30. Name and address of person who completed cause of death (Item 23a) (Type, Pri 1. Date filed (Month, Day, Year) 32. Registrar's Signature	ROAD BAIF		arylano 21212
Registra DHMH 17 Rev 1/20	ar	JAN 0 7 2005 A STORY ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month KODE 0140 /Medical 04 12 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CAMPWAVE TYE. CLEDTENTOWN Hd. Heron Point 501 3 Kent 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 SGF Hours Days 360-38-8075 Yrs. Director Montaña Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or Items 23e or 28a-f shov other treumetic event, the Madical Examinar must be notified at Completed by Funeral Director Kent 1 ☐ Yes 2√ No Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 E. Campus Avenue 21620 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white 3 ₩ Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otto Henry Koch Wilhelmina Augusta Carlson ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Robertshaw/son 429 Heron Point Chestertown, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 9 permit. Page Department of Importent: If eny injury or once. 21. Signature of Europa School Sande Nade Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 entecle 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR ACCIDENT Physician 5 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Jula to (or as a consequence of) burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death Month Day Year 5 Other (specify) the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform 2 No 1 Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner

Division of Vital Records, P.O. Box 68760,

or Attending Physicien: The law requires that the death certificate be executed this certificate After s after dea. within 24 hours a To the Funerel C

P

Certification:

Medical

1 □ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 □ DOA Other: 4 → ursing	g Home 5 Residence 6 Other (Specify)
27. Manner of Death 17. Natural 5 Pending 2 Accident investigation		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, death on the basis of examination and/or invested. and manner stated.	occurred at the time, date and pla stigation, in my opinion, death oc	ace, and due to the cause(s) and manner as stated. ccurred at the time, date and place, and due to the cause(s)

Helen A 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

82. Registrar's Signature Daves

122

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Noble

2005

Siste 5 Chestertoun Mr Rd Speer

D0041587

29d. Date signed (Month, Day, Year)

Other:

			For State Registrar	State of Ma		partment of F Prtificate of			giene Reg. No.	+ 42621
	Physici /Medic		Decedent's Name (First, Middle, La	Theodor:	ie Smith	- Counts		2. Date of Dea Month 12	31 200	3. Time of Death 9: 45 aM
	Examin		4a. Facility Name (If not institution, given				r Location of Death)	4c. County of Do	eath
			Joseph Richey 5. Social Security Number 6.5		e (In yrs. last birthda	Balto y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	N/A	Birthplace (State or Foreign
П	Funeral Director		219-20-7205 A	1□ M 24 F	85 Yrs.	Months Days	Hours Min.	(Month, Day 12-7	-1919	Country) Va
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Maryl -f sho	tor	Md	N/A	Balto					1 No
	th the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	s 23a	ral	2338 N. Monore		e santa de la la		217		USA	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or ttams 23a or 28a-f show evant, the Medical Examinat must be notified at evant, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2020 If Yes, Give Year or Dates:	ever in U.S.	8. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Al Black, W Specify:	merican Indian, hite, etc. Black
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121	filed within Hygiene. Ithar than " int, the We	Completed	Elementary/Secondary (0-12) 9th grade	College (1-4or 5)+)	feteria Wo			Baltimore Public Sch	•
nd	be filed ntal Hygi od othar evant, II	BeC	17. Father's Name (First, Middle, Last	')			18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	
Maryland	2 should be filed within and Mental Hygiene. is marked othar than raumatic evant, the M	70	Winder Smith	T 010	V		Lovely			
Ma	2 6 8 2		19a. Informant's Name/Relationship	**		iling Address <i>(Street)</i> 7 Bluff Po				
Jre,			20a. Method of Disposition	7	20b. Place of Dis			Date	20c. Location - City	
Baltimore,	nit. Pages artment of I ortant: If it injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci	(y)	Loudon	Park Ceme	tery 1-6		Balto, Mo	1
Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	H. Dhom	Dam		ash Aven	ue Balto	, Md 2121	5
			23a. Pert1. Enter the disease, or con shock, of heart failure. List only Immediate Cause (Final	plications that caused one cause on each lin	the death. Do not e	nter the mode of dyin	g, such as cardiac	or respiratory are	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Due to (or as	a consequence of):		28			years
b	Examiner		Convention to the line and divine	b Ce		scular c	lisease			-1
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IJ	execute and al-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as:	a consequence of):					
68760	ficate be executed physician and is the burial-transit	edical E		_ d						
	± 0.€		IF FEMALE:							
Box	death certifi e attending d for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	4□Pregnant at	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of o Month	lelivery Day Year
P.0	that the de ed by the a detached	Phys	9 🗆 Unknown	9□ Unknown				1		
	w requires tha been signed should be de	by	Part II. Other significant conditions	contributing to death bi	ut not resulting in the	underlying cause give	en in Part I.			to the cause of death? Probably 4 Tunknown
of Vital Records,	The lar	Completed				_		24a. Was a autops perform	sy prior to	
Vita	sician certifi rector) Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	-t 0. T. F.D. (2 to 1)	ont 3 DOA Oth	26. Place of Deal			- Hearing
	g Physier this	n; To	27. Manner of Death	28a. Date of Injur (Month, Day	nt 2 ER/Outpati ry 28b. Time (Year) Injury	of 28c. Injun	y at	ome 5 ☐ Reside 28d. Describe he	ence 6 Other (Sp ow injury occurred	becify) Hospice
sior	Ntanding death. ctor: After y the funer	atlo	1 Natural 5 Pending 2 Accident investigation	n	rour/ injury		Yes 2 □ No			
Division	- M O	Certification;	3 Suicide 6 Could not be determined		ury - At home, farm, : c. (Specify)	street, factory, office		28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the completely filled in the funeral or	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best ominer: On the basis of and manner sta	examination and/or	ath occurred at the tin investigation, in my o	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within 2 To tha complet	Ž	29b. Signature and title of certifier			29c. License		1	9d. Date signed (Mo	
•	1		2 80 W)	4 4	<u> </u>	4170		Decembe	r 31,2004
	7		30. Name and address of person who	ichey tos	path (Item 23a) (Type	& NEut	aw st	Baltima	reMD 2	1201
	Sta		31. Date filed (Month, Day, Year)	32. registra	ar's Signature	perker			,	•
	Registr	ar	JAN 0 7 2	005 Acres	0 11					

Theodorie Courts Islailley 945Am

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		nt of Health and Mental Hygiene lite of Death	11. 1.2622
Physiciai /Medica	1. Decedent's Name (First, Middle, Last) ROSalie SKOVYOV	2. Date of Death	3. Time of Death
Examine	4a Facility Name (If not institution, give street and number) Roland Park Place	4b. City, Town, or Location of Death 4c. Cour	nty of Death
Funeral Director	5. Social Security Number 6. Sex 1 □ M 2 □ F 7. Age (In yrs. last birthday) 1 □ M 2 □ F 96 Yrs. 6. Sex Month 1 □ M 2 □ F 1 □ M 2 □		9. Birthplace (State or Foreign Country) New York
e Marylence et show	10a. State 10b. County 10c. City, Town or Location Baltimore		10d. Inside City Limits 1 X Yes 2 □ No
th with th	10e. Street and Number 10f. 2	01011	of What Country?
5-0036 72 hours after death with the Maryler natural; or items 23e or 28e-f show digal Examiner must be notified at	1 Never Married 2 Married 1 Yes 2 No		ace - American Indian, lack, White, etc. cify: White
yland 21215-0036 uid be filed within 72 hours after death with the Maryland Mental hygiene. riked other than "natural", or items 23a or 28a-f show tite event, the Medical Examinat must be notified at	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 16a. Decedent's Us (Give kind of shife. DO NOT) life. DO NOT	ork done during most of working use retired)	Business/Industry
Maryland 212 d 2 should be filed withi th and Mental Hygiene. 7 Is marked other than traumatic event, the M	17. Father's Name (<i>First, Middle, Lest)</i> Morris Salkind	18. Mother's Name (First, Middle, Maiden Suma Julia Junowich	ame)
re, Mary 1 end 2 sho 1 Health and 1 tem 27 is me other traums		ss (Street and Number or Rural Route Number, City or Towney Spring Drive Baltimore, ame of other place) Date 20c. Location	
Baltimo pemit. Pages Depertment of Important: If It any Injury or a	21. Signature of Euneral Service Licensee Ronald S. Wade, Director State	and Address of Facility Anatomy Board 655 W. Baltin	more Street
requires that the death certificate be executed requires that the death certificate be executed where signed by the ettending physicien end chould be deteched for use as the buriel-transit where the physician medical Examiner	23a. Pakt. Enter the disease, or complications that caused the death. Do not enter the misshoot, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Due to (or as a consequence of Carly leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause. Due to (or as a consequence of Carly leading to immediate cause.)	. L A): , A	Approximate Interval Between Onset and Death
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Il Records, The lew requires th ate has been signed page 2 should be d	Coronary Artery dist	A S E 24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital Rec sician: The lew certificate has b lirector, page 2 s	25. Was case referred to medical	26. Place of Death (Check only one)	1 ☐ Yes 2 ☐ No
Division of Vital Records, To the Hospital or Attanding Physician: The law requires the within 24 hours effer death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be to Medical Certification: To Be Completed by	examiner? 1	OA Other: 4 Nursing Home 5 Residence 6 OI 28c. Injury at Work? 1 Yes 2 No	urred
E Hospital 124 hours e Funeral E letely filled	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurre 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	l at the time, date and place, and due to the cause(s) and n h, in my opinion, death occurred at the time, date and place	nanner as stated. e, and due to the cause(s)
To the within To the complex c	29b. Signature and title of certifier Signature and title of certifier 22	D35102 JANUA	red (Month, Day, Year) XY 4, 2665 XY Ano 21212
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	m/n	Tivilly,

Emma Henrietta Snyder

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

0.100	ion	Decedent's Name (First, Middle								2. Date of D		L U	rear	3. Time of D
Physic /Medi		Emma Henrie	tta Snyder							DECEMB	ER 2	1, 20	04	1:13P.
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uneral irector		5. Social Security NumberUnK Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. 87	. last birthday, Yrs.	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D Nov 27	th ay, Year) 19	17	9. Birthpl Count	ace (State 41) ry)
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F B	ţ	MD Anne	Arunde1		S	evern								1 ☐ Yes 2
or 28,	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	izen of Wh	at Count	ry?
123a	ral	629 Queenstown						1144				USA		
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mental hyglene. arked other then atic event, the M	Be	17. Father's Name (First, Middle,	unk Last)				unk	18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)		
tem 27 is marked of	To	19a. Informant's Name/Relations O.C.M.E.	hip (Type, Print)							More,		r Town, St 21201	ate, Zip (Code)
Important: If item 2: any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🖾 Other (S	pecify) in sta	tate	Place of Dispo cemetery, crea	osition (Nam matory or ot	ne of ther place	9)	C	ate	20c. Lo	cation - Ci	ty or Tov	vn, State
Import any inj		21. Sign true of Funeral Septice Rome 1 d	Licensee S	irecto	r Si	^{2. Name and} tate A altimo	Anato	my B	oard 21201	655 W.	Bal	timo	re S	treet
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DHMH 17 Rev 1/2001

Robert Lee Snyder

Physician			(First, Middle.	Last)			artment of 1839 1- rtificate			2. Date of Dea			426	
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/Medical Examiner	4	a. Facility Name (If n	not institution,	give street and n	number)		4b. City, To	wn, or Location	on of Death	DECLI IDE	4c. County		1:13P	•
		629 QUEEN						EVERN			ANNE	ARUN	DEL	
Funeral Director		S. Social Security Nun		6. Sex 1∭ M 2□ F		yrs. last birthday) 6 Yrs.		Year If Und Days Hour	der 24 Hrs. S Min.	8. Date of Birth (Month, Day Mar 2,	1948	9. Birth Cou	place (State o intry) U	r Foreigi nk
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in liems 23s or 28s-f st in act rivast be notified rector		10e. Street and Numb					10f. Zip Co	ode		1	0g. Citizen of	What Cou	intry?	
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am 27 ther to	-	O.C.M.E.			20	111 b. Place of Dispo				imore, M				
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	Physicia /Medic		JAMES 7. SCHMIN	i K	December	13,2004 21:51pm
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c.	County of Death
	Funeval		5. Social Security Number 6. Sex, 7. Age (In yrs. last birthda)	of Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		214-44-0244 1XM 20F 56 Yrs.	Months Days Hours Min.	Month, Day, Year)	47 Country MD.
	pur *		Usual Residence of Decedent 10a. State 10b. County 1 10c. City, Town or I	ocation		10d. Inside City Limits
	Maryla f sho	o	MD. NA RALT	1		1 Yes 2 □ No
	7 28a-	rect	10e. Street and Number	10f. Zip Code	10g. Citi	zen of What Country?
	th with	a	508 S. CLINTON ST.	21224		D-5.A.
	tems ut.	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13 Amned Forces? 13	. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:		Specify: // ///TE
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Baltimore,	Pages tment of l tant: If it		'4 □Donation 5 □Other (Specify)	NHOREST XXX		TO-CO., MD.
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	To the Hospital or A within 24 hours after To the Funeral Director Completely filled in b	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, an nvestigation, in my opinion, death occurred	nd due to the cause(s) d at the time, date and	and manner as stated. place, and due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number	29d. Date	e signed (Month, Day, Year)
			malor mo.	Res 000	Dec	ember 17,2004
V	1h				Dec Baltim	NO NA 21720
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			1 - For State Registrar	State of I	Maryland		artmen rtificat					giene Reg. No	0	nı.	10000
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	/Medi		JULIA BOYER SPEA				_				Decemb	er 3		2004	12:20 p M
4	Examir	ner	4a. Facility Name (If not institution, gi				4b. City,	Town, or	Location	of Death		4c	. County	of Death	
			Doctor's Communation 5. Social Security Number 6.		tal Age (In yrs. last	hirthday)	Lan If Under	ham	If Under	24 Hrs	0.0-1(0)				orge's
	Funeral Director			1□ M 2XF	83	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da Feb. 4,	y, Year) 192	21	9. Birthp Coun Mary	
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Midical Examination ust be molified at		10a. State 10b. County		10c. City, T	own or Lo	ocation							1	0d. Inside City Limits
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036	ral', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Date			1 ☐ Yes 2	No No	Specify:				Specify	y: Whi	te
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, Ire McGral Examiner must be rediffed at 200e.	Completed	15. Decedent's E (Specify only highest gi	ducation a de completed)	10	6a. Dece	dent's Usua	l Occupa	ition	t of worki	ina	16b. K	ind of B	usiness/Ind	ustry
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ı	Dharisisa		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	One cause on each	i iirie.		er the mode	of dying	, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Between Onset and Death
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۵.	igned b	by Ph	Part II. Other significant conditions	ontributing to death	but not resulting	in the un	derlying car	use giver	n in Part I.		23e. Did to	bacco us	se contr	ibute to the	cause of death?
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		edical	29a. Certifier 1 X Certifying Ph (Check only one) 2 ☐ Medical Exar	ysician: To the bes niner: On the basis and manners	or examination a	ge, death ind/or inv	occurred at estigation, i	the time	, date and nion, death	place, a	nd due to the ca d at the time, d	ause(s) a ate and p	and mar place, a	nner as stat nd due to th	ed. ne cause(s)
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 tem#28a-e, perME, G339, 1//05 III
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2004 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Year Month **Physician** December 26, Thomas Arthur Stevens 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner York Road-Bee Tree Road Parkton Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min. 12M 2 F 47 Yrs. 217-76-0864 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f ehow the Medical Examiner right be notified at 1 Yes 2 No Director Baltimore Parkton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21120 20012 York Road United States or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1€ZYes 2 □ No If Yes, Give Year or Dates: 75-78 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status lited within 72 hours after Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore Gas & Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Lineman Electric 12 Pages 1 and 2 should be filed nent of Health and Mental Hygiant: If Item 27 Is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Carol Charshee Clarkson G. Stevens, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 403A Irwins Choice Road, Bel Air, MD 21015 Mrs. Carol Dankmeyer/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Dec 29 1 Burial 2 Cremation 3 Removal from State = 0 permit. Page Department of Important: if any injury or once. Beltsville, MD 4 Donation 5 Other (Specify) Chesapeake Crematory 2004 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation and Funeral Alternatives M00986 Thelel 8717 Green Pastures Drive Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) To Head Gur SHOT Physician 10 minutes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an certificate has autopsy performed? Yes 22 No 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: Yes 2 No 4 Nursing Home 5 Residence 6 Nother (Specify) STreeT 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 13:50 p^M within 24 hours after death. To the Funeral Director: A 12/25/2004 2 Accident Subject shot himself the 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide roadway 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number D18667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Trumble Hill CT. Lutherville, Maryland Lello 6 32. Resistrar's Signature 31. Date filed Wonth, State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Linda Stine 4:10 p. December 30, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deeth Forest Haven Nursng Home Catonsville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Days Hours Director October 20, 1950 Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County r than "natural", or Itams 23a or 28a-1 show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 U.S.A. 315 Ingleside Ave filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: White à 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Handicapped Elementary/Secondary (0-12) College (1-4or 5+) Handicapped unk. it of Health and Mental Hygie If item 27 is marked other or other traumatic event, II other I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Dorothy Holden George Faustman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 21 Simpsonville, Maryland 21150 Ms. Eileen Shields Executrix 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, Stete Important: If i Burial 2 Cremation 3 Removal from State 4 □Donation 5 □Other (Specify) Marriottsville, Maryland 01/04/2005 Crest Lawn Memorial Gardens permit 21. Signature of Funeral Service Liq 22. Name and Address of Facility Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition METASTATIC **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Seque maily list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner law requires that the death certificate be executed and physician as Due to (or as a consequence of) as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Month Yes 2 No 9 □ Unknown Day 4 Pregnant at time of death 5 Other (specify) P.O. the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ page 2 should 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ ₩0 has certificate of Vital 1 Yes 21110 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 4 Aursing Home 5 Residence 6 Other (Specify) Sitt 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: or Attending Patter death.

Director: After 1 28d. Describe how injury occurred Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospite Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SULCELLA 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin 1/ts NEEM AKHANI, 7220 DAUD MD 21208 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

			1 - For State Registrar	State of Mary	land / Depa		Health and	Mental Hyg	iene2 0 0 4	42629
	Physici /Medi		1. Decedent's Name (First, Middle, La Jeanette M. Tayl					2. Date of Dea Month Decembe	Dav Year	3. Time of Death 4 4:45 a M
	Examir		4a. Facility Name (If not institution, giv HCR Manor Care D 5. Social Security Number 6. S	ulaney		4b. City, Town, Towson			4c. County of Dea Baltimon	re
	Funeral Director			ox 2	yrs. last birthday) Yrs.	Months Days			Year) 9. Bir Ci 1916 Ma	thplece (State or Foreign ountry) aryland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "netural", or Items 23a or 28a-f show any figury or other traumatic event, the Medical Examinar must be notified at once.	Funeral Director	10a. State 10b. County Md. Harfor 10e. Street and Number 20 Box Hill Sout	d		Abingdon 10f. Zip Code		1	0g. Citizen of What Co	•
9800	nours after death ural', or Items 2:	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of If Yes, specify Cu 1☐ Yes 2☑ No	Hispanic Origin? (S ban, Mexican, Puer o <i>Specify:</i>	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify: V	erican Indian, le, etc. vhite
1215-	within 72 h ene. than "neti	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12 years	de completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	upation e during most of wo ed)	orking	16b. Kind of Business OWN home	•
Maryland 21215-0036	ould be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) John Truelove			-MCCC2		me (First, Middle, I	Maiden Sumame)	
, Mar	and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship (Nancy Hanna/daug	hter	6209	Edgewoo		Apt. D, E	City or Town, State, . Edgewood, N	D 21040
Baltimore,	t. Pages 1 tment of H rtant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☆ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Bayview C	matory or other pla Crematory	12/		20c.Location-City or Baltimore,	
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	/Medical Examiner	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	ansequence of):	iseas		o or roop, and		Interval Between Onset and Death
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	T W T	_) e a		(Ham 222) (Trus). Hoo	5442		1-5-0	
	10		30. Name and address of person who Cyrus Asadi, M.D 31. Date filed (Month, Day, Year)	., 111 West	Road, To					
	Sta Registr	-	JAN 1 1	32. Registrar's S	ayrrature /	barte !				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2004 Mary Tinsley /Medical 4b City, Town, or Location of Death 4M Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner 24 Hrs. 8. Date of Birth Min. (Month, Day, Year) 4ichae 6. Sex If Under Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days Months Hours 1□M 2√2 F 213-16-7172 83 Director June 26,1921 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth end Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State I is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at Baltimore Yes 2 No Baltimore City Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? United State 21215 4800 Seaton Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Merried Specify Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by 3 □ Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) James O. Teagle Effie Jones 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5004 Ivanhoe Ave. Baltimore, Md 21212 Howard Jackson other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Trinity Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 12-31-04 Dundalk, MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wesley Chavis Jr. Funeral Home 2007 Eastern Ave. Baltimore, Md21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical End Stage Zin **Examiner** Due to for as a consequence of): Examine Dialutes To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death. Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed hes le 2 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: I Director: After to in by the funeral 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 017537 12-30-04

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) DARSHAN, S. SALU)A 1600 W. HOUNTROYALAUR, Balto 21217

Registrar

DHMH 16 Rev 6/95

State

31. Date filed (Month, Day, Year)

			For State Registrar	State of M	aryland			of He	ealth and	Mental Hy		2001	1 42631
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	Funeral Director		5. Social Security Number 073-68-3836	hack Trav		ast <i>birthd</i> ay) Yrs.	If Under 1	Ba	h may If Under 24 H Hours M	rs. 8. Date of Bi	rth	9. B	irthplace (State or Foreign Country) New York
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Howa	rd		Town or Lo							10d. Inside City Limits 1 ☐ Yes MXNo
	ath with the 23a or 28a	Funeral Director	10e. Street and Number 5214 Forest Me	adow Court			10f. Zip (Code 21043				en of What C	Country?
9600	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 Is marked other than "natural", or Itams 23a or 28a-f show or other traumatic evant, the Medical Examinan must be notified at	by	11. Marital Status Y Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Yes Give Year or Dates:			Was Decede f Yes, speci I ☐ Yes 2		panic Origin? Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		4. Race - Am Black, Wh Specify: A	
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Baltimore, Ma	Pages 1 and 2 sent of Health arent of Health arent: If item 27 is		Kin Tom - fathe 20a. Method of Disposition 1 □ Burial 2 🏋 Cremation	r 3 □Removal from State	20b. Pla		Fores	t Mea	adow C	ourt, Ell Date 3-2005	icott	City ation - City o	, MD 21043 r Town, State
Baltin	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service L	telema		Ga 72	Name and Lry L. 250 Wa	Address Kau: shin	of Facility Eman Fig Ton B.	neral Hollyd., Elk	me@M ridge	sville Meadown	ridge MP, Inc. 21075
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8760,	ate be executed thysician and the burial-transit.	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b				(1)	Mel	HOUGH EN MEDICAL EN	AMINER	V V	
O. Box 6	death certificate e attending phys id for use as the	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal d	death 3 🗌	Ectopic pred	gnancy	CEHON AP			d. Date of de Month	livery Day Year
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Vital Record	The taw ate has b page 2 s	e Completed	25 W							24a. Was autop perfo 1 □ Yes	an osy rmed? 2 No	24b. Were a prior to death?	utopsy findings available completion of cause of s 2 \(\simegap \) No
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	To the Hospital within 24 hours a To the Funeral C completely filled i	Medical	29a. Certifier (Check only one) 2 ☐ Medical Example 29b. Signature and title of certifier	Physician: To the best of caminer: On the basis of and manner sta	examinatio	edge, death in and/or inv	estigation, in	the time, n my opin License n	ion, death occ	curred at the time,	date and p	lace, and due	s stated. $\mathcal{M} \mathcal{D}$ to the cause(s)
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	.7*	20	Decedent's Name	e (First, Middle,	_ast)							2. Date of De	ath				of Death
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	Examin		4a. Facility Name (/	f not institution, g	ive street and nu	mber)		4b. City, To	wn, or Lo	ocation o	f Death		4c	. County o	Death		
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ľ	Funeral Director		5. Social Security N 248-48-	-5961	.Sex 1 □ M 2 🖾 F	7. Age (In yrs	s. last birthday) Yrs.	Months D		If Under 2 Hours	Min.	8. Date of Bir (Month, Da Oct 31	th ly, Year)	934 s	3. Birthp. Coun Outh	ace (State try) Car	te or Foreign olina
	land		Usual Residence of 10a. State	10b. County		10c. C	ity, Town or Lo	cation									City Limits
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician MARGARET DEC /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner BALTIMORE MILLENIUM NURSING HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 225.F 72-4945 Yrs. 1 ARYLAND PRIL Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Dapertment of Health and Mentel Hyglene. Imprortant: if Item 27 is marked other than "naturel; or items 23e or 28e-f show any Injury or other treumstic event, its Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1Д Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? AVENDISH Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in 4,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2/24No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BLUE CROSS BLUESHIELD 2+HGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) TURNER JOHN ARLENE (DALKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ATANYA KOBINSON 1000 BROOK SISTER BALTO, MD. 2121 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 N Burial 2 □ Cremation 3 □ Removal from State CEMETERY 4 Donation 5 DOther (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses FUNERAL HOME 40 ULTON 23a. Part1. Enter the discharge e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are List *only* one cause on each line. Approximata Interval Betwaen Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner by Physician/Medical Examiner or Attending Physicien: The lew raquires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown To the Hospital or Attending Physicien: The lew raquires twithin 24 hours effer death.

To the Funeral Director: After this certificate has been signiconpletaly filled in by the funeral director; page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 202No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of De 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 □ Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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DHMH 16 Rev 6/95

			1 - For State Registrar	State of M	larylan		artment of			-	giene Reg. No.	04	4263	35
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	Examin	ier	4a. Facility Name (If not institution, given 1419 N. Central		7)		4b. City, Town,	or Location ltimo:			4C. CO	unty of Death		
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X O D	the death certifica y the attending ph tched for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			DEctopic pregnan				23d	. Date of delive	ry	
0	death	sicia	in the past 12 menths?	4☐Pregnant 9☐Unknown	at time of d		Other (specify)					Month	Day Ye	ar
т Э	at the d by th etach	Phys	9 Unknown											
Ś	requires that been signed b hould be deta	by	Part II. Other significant conditions	contributing to death	but not res	utting in the u	inderlying cause g	iven in Part	1.			contribute to the lo 3 □ Prob		
Records	needu been	Completed								-				
ec	as s	ldm						· · · · · -		24a. Was autop		4b. Were autoprior to condeath?	osy findings av npletion of cau	
		e Co	25. Was case referred to medical							1 Yes	2 12 No	1 🗌 Yes	2 No	
5	Physician: The this certificate hiral director, page	0 B	examiner?	Hospital:	itient 2 🗆	ER/Outpatie	nt 30 004 0	th n m		(Check only o		Other (Specify		
		n: T	27. Manper of Death	28a. Date of Ir		28b. Time o	f 28c. lnj			28d. Describe			·/	
0	Attending r death. sector: After oy the fune	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accidentinvestigation	on	Jay rear,	Injury		Yes 2]No					
DIVISION	irecto	Certification:	3 Suicide 6 Could not determined	286. Place or	Injury - At he etc. (Specil	ome, farm, st	reet, factory, office	9	. 2	28f. Location (City or To	Street and N wn, State)	lumber or Rura	l Route Numb	9 <i>r</i> ,
ב	urs af urs af erel D		*											
	Hos 24 ho Fune	edical	29a. Certifier 1 12 Certifying P (Check only one) 2 Medical Exa	hysician: To the be miner: On the basis and manner	of examina	owledge, deat ation and/or in	h occurred at the vestigation, in my	time, date a opinion, de	nd place, a ath occurre	and due to the ed at the time,	cause(s) and date and pla	d manner as st ace, and due to	ated. the cause(s)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Med	29b. Signature and title of certifier		Jiaiou.		29c. Licer	nse number				igned (Month,		
	->-0		> unejandoa	e KD			DI	6619			JANG	CARY C	, 2005	5
1	3		30. Name and address of person who	completed cause of	f death (Iter	n 23a) (Type,	Print)		,					
_	/		A VEREARA-C	MAPFC 9	040 8	-DANIE	1341 SA	LARE	DRIV	E, BA	4/MA	RE, M.	D. 212	36
	Sta		31. Date filed (Month, Day, Year) JAN 0 7 200	22. Regi	strar's Signa	ature	Se D							
1	Regist	rar	JAN 0 7 200	D ARREST	e so	No year								

DHMH 17 Rev 1/2001

Privation Vincent L. Wright A Facily Name (if no extinuor, post stream and number) 40. Cby, Town, or Location of Death 40. Cby, Town, or Location 40. Cby, Town or Location 40. Cby,			1 - For Amend Item 2	State of Manylan per me 6839 1	d / Depa Cer	rtment of F tas tificate of	lealth and Death		giene Reg. No2 (004	42636
Source in the control of the control	_		1. Decedent's Name (First, Middle, Last) Vincent L. Wrigh	t				Month 1	Qay	-04 2004	3. Time of Death 5:59 P M
2 Secretary Number 2.5 Sec 2.5 S								ath	4c. Coun	ty of Death	
180 180			5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 H		th (9 ^{ar)}	9. Birth	place (State or Foreign ntry)
The present warm (First, Models, Last) Sandra Wright Sandra Wrig	Maryland f show	ior	10a. State 10b. County	e Balt	,Town or Loc imore	cation					10d. Inside City Limits 1 1 1
The present warm (First, Models, Last) Sandra Wright Sandra Wrig	h with the 1 3a or 28a-	al Direct							-	f What Cou	ntry?
The present warm (First, Models, Last) Sandra Wright Sandra Wrig	036 urs after deat al', or Itams 2	þ	X Never Married 2 Married	Armed Forces? 1 ☐ Yes X☐ No If Yes, Give				(Specify Yes or No erto Rican, etc.)		ack, White,	
The purpose of the pu	1215-0 vithin 72 ho ne. han "natur a Medical I	mpleted	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give	kind of work done of NOT use retired	during most of w	orking			
23. Part I. Enter the disease of complications that carled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fault fault of the clause (Phat Teaching of death and the clause of death and the clause (Phat Teaching of death and the clause of death and the clau	land 21	Be	17. Father's Name (First, Middle, Last)	t Sr.		0				ame)	
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23. Part I. Enter the disease of complications that cardied the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear it alrayout a story) on cause or each ine. **Priyation** **Medical Examiner** **Immediate Cause (Final Teach Interval Beyond Story) on cause or each ine. **Due to (or as a consequence of): **Due	altimore, mit. Pages 1 a partment of Her cortant: If itam injury or otha		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Wo	odlaw	Cemete Name and Addre	ss o Facility W	-05 Jeslev (Balti	more,	Co.
Projection Medical Examiner General Medical Examiner General Medical Examiner General Medical Examiner General Medical Examiner General Medical General General General General	B P P P P P P P P P P P P P P P P P P P	1	23a. Part 1. Enter the disease of complic	cations that caused the death	20	00/ East	ern Av	e. Balt	imore	, MD	21231
Sequentially list conditions: Sequentially list conditions: Due to (or as a consequence of):	/Medical		Immediate Cause (Final disease or condition	Multiple	e 9	unsho	+ Wo	unds			Interval Between Onset and Death
Section Part	A Co is	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.		uence of):						
FFEMALE: 123b. Was decedent pregnant in the past 12 months? 123b. Was decedent pregnant in the past 12 months? 123b. Was decedent pregnant in the past 12 months? 123b. Was decedent pregnant at time of death 123b. Was decedent pregnant at time of death 123b. Was decedent pregnant 125b. Was	3760,ate be exected the burial-trainer.	lical Exa		Due to (or as a consequ	uence of):						
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Death (Check only one) 28. Death (C	O. Box 61 he death certific the attending p ched for use as:	yslclan/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of di	Ideath 3□		,				-
25. Was case referred to medical examiner? 10 years	dS, P.	þ	Part II. Other significant conditions conf	tributing to death but not rest	ulting in the ur	nderlying cause giv	en in Part I.		V		
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and dute to the cause(s) and manner as stated. 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARDL H. ALLAN W. 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature	I Record The law requate has been page 2 should	Completed						24a. Was auto y perfo	an 24b	. Were auto	opsy findings available impletion of cause of
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and direct of the cause (s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARUL H. ALLAN W. 111 Penn Street, Baltimore, Maryland 21201 31. Date filled (Month, Day, Year) 32. Registrar's Signature	f Vita ysician: ysician: is certific director,	Be	examiner?	ospital: 1 Inpatient 2	ER/Outpatien	3 DOA Oth	00			ther (Speci	y) at scene
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and dates of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filled (Month, Day, Year) 32. Registrar's Signature and 21201	Oivision or or Attanding Photes of Attanding Photes Photes Prince of the tuneral in by the funeral		1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he building, etc. (Specify	5:34	PM 10	y at k? Yes 2 XNo	28f. Location (City or To	Street and Num	+ S V	Balture
2 Caral Hallan Wd O.C.M.E. December 31, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAROL H. ALLAN Wd 111 Penn Street, Baltimore, Maryland 21201	Hospital Hospital Puns 8 Funaral I		(Check only 2 Medical Examin	ician: To the best of my kno er: On the basis of examina	wledge, death	occurred at the tin	ne, date and pla pinion, death oc	ce, and due to the	cause(s) and n	nanner as s	stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAROL H. ALLAN W. 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature	To the within 2 To tha comple	Med		010an wd							
Ctors 31. Date filed (Month, Day, Year) 32. Registrar's Signature	2		30. Name and address of person who cor	mpleted cause of death (Item		Print)					
			31. Date filed (Month, Day, Year) JAN n 7	32. Registrar's Signa	ture	# .4			·		
DHMH 17 Rev 1/2001 ORIGINAL			OAN U (Gover					

		•	For State Registrar	State of	of Marylar		artment of H		d Mental Hy	giene Reg. No. 200	4 42637
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle Carol 44. Facility Name (If not institution)	Wil	liams	son	4b. City, Town, or	r Location of De	2. Date of De Month		4 3.00 PM
	Funeral Director		5. Social Security Number 237-15-2091	BAYVIEW C	7. Age (In yrs. 41		Bath. If Under 1 Year Months Days	If Under 24 H	din. 8. Date of Bir (Month, Da	h 7 ~~	irthplace (State or Foreign Country)
	Maryland	tor	Usual Residence of Decedent 10a. State MD 10b. Count Balti	more Cit		ty, Town or Lo					10d. Inside City Limits 1X Yes 2 □ No
	th with the 23s or 28s	Funeral Director	10e. Street and Number Bayview Nurs	ing Home	<u> </u>		10f. Zip Code 21231			10g. Citizen of What C	Country?
980	72 hours after death with the Maryland natural', or Items 23s or 28s-1 show disal Evantiner must be incilled at	by	11. Marital Status 1 XNever Married 2 Ma 3 Widowed 4 Divorce	Armed Fi	2 X No ive No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? an, Mexican, Pu Specify:	? (Specify Yes or No uerto Rican, etc.)	Specify: B1	iite, etc.
21215-0036	within ene. than "	Completed		est grade completed) College ((Give	dent's Usual Occup kind of work done of DO NOT use retired Maker	during most of	working	16b. Kind of Busines	s/Industry
Maryland 2		To Be C	17. Father's Name (First, Middle Howard Willi						Name (First, Middle atlinto)	, Maiden Sumame) N	
	ges 1 and 2 should t of Health and Mer If Item 27 is marke or other treumatic	8	19a. Informant's Name/Relation George L. Wi		201	590	ng Address <i>(Street a</i> Main St. position <i>(Name of</i>	and Number or • Hack	Rural Route Numb ensack,		
Baltimore,	Pa men ant: ury	1	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other 21. Signature of Fune 1 Septe	(Specify)	C1-4-	cemetery, cre yview	cremato 2. Name and Address	ry 1-3	3-05	Baltimore	
Ba	Departi Departi Importi any inj		23a. Part1. Enter the disease shock, or heart failure.	s Cha	caused the dea	We	sley Cha	avis J	ve Ral	ral Home timore, M	d 2 12 3 1 Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Hun	ting to 1	si Di	sease-				Onset and Death 12 Years
€0°, 109.	ate be executed hysicien and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 c	(or as a consec						
.O. Box 68760,	death certific e attending p id for use as f	Physiclan/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	itcome of pregn birth 2 Fet nant at time of a	aldeath 3	Ectopic pregnancy Other (specify)	,		23d. Date of do	əlivery Day Year
S, T	sign d be	by	Part II. Other significant condi	tions contributing to c	leath but not re	sulting in the u	inderlying cause give	en in Part I.	23e. Did t	obacco use contribute Yes 2 No 3 F	to the cause of death? Probably 4 □Unknown
Vital Record		Completed							24a. Was auto perio 1 1 es	psy prior to ormed? death?	
	ding Physician: Th th. After this certificate funeral director, pag	tlon; To Be	25. Was case referred to medic examinar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pencinyes	Hospital: 1 28a. Date		ER/Outpatier 28b. Time o Injury	f 28c. Injun Worl	er: 4 Nursin	-	one) dence 6 □Other (Sp how injury occurred	ecify)
Division of	ne Hospitel or Attending 124 hours after death. Ne Funerel Director: After bletely filled in by the fune.	Certification:	3 ☐ Suicide 6 ☐ Coul	d not be 28e. Place	e of Injury - At h ling, etc. (Speci	ome, farm, sti	reet, factory, office		28f. Location (City or To	Street and Number or F wn, State)	Rural Route Number,
	# # # # #	edical	(Check only 2 Medica	al Examiner: On the band man	e best of my knoossis of examination	owledge, deat ation and/or in	vestigation, in my of	pinion, death o	ace, and due to the courred at the time.	cause(s) and manner a date and place, and du	e to the cause(s)
)	Neith To Toor	Σ	29b. Signature and title of certif	Coll t	- 2	70	29c. License			29d. Date signed (Mor	
R	Sta Registr		30. Name and address of person michela. F. 31. Date filed (Month, Day, Yea	Bellant	ani, mi	m 23a) (Type,	Print) 505 Hap	oKins	BAYULEL	Circle, E	9-2004 Boltimere, ml

DHMH 17 Rev 1/2001

		ı	1 - State	State of M	Marylar	nd / Depa		of Heal	Ith and	Mental Hy	giene 0 0	14 4263	38
			Registrar 1. Decedent's Name (First, Middle,	Last)			.,,,,,,,,	0, 000	<i>,</i>	2. Date of De	Reg. No.	3. Time of De	ath
	Physici	an	Sulema Atkins	,						Month Decend	Day	Year ///	
	/Medic		4a. Facility Name (If not institution,	aire street and number	ar)		4h City To	wn or loca	ation of Deat		4c. County (, ,	
	Examin	ier		gers Hos		P	,	ev ex		11	Paine		
						last birthday)	If Under 1		Inder 24 Hrs	. 8 Date of Bir		9. Birthplace (State or Fo	Soreign
	Funeral Director		578-06-6042	1 M 2 🖾 F		3 Yrs.			ours Min		y, Year) , 1971	Country) Panama	ureigii
			Usual Residence of Decedent							nag. o	, 25/2	Lanama	
	yland 10w		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City L	Limits
	the Marylar 28a-f show	ţ	Maryland Prince	George's		Gree	nbelt					1 ☐ Yes 2[∑ No
	1 the	Jec.	10e. Street and Number				10f. Zip Co	ode			10g. Citizen of W	hat Country?	
	3a o	by Funeral Director	6204 Springhil	l Drive. #	202		20	770			Pana	ma	
	ns 2	era	11. Marital Status	12. Was Decede	nt Ever in U	I.S. 13.			ic Origin? (9	Specify Yes or No to Rican, etc.))- 14. Race	- American Indian,	
10	r ka	필	1 Never Married 2 Marrie	Armed Force d 1 ☐ Yes 2						to Rican, etc.))	, White, etc.	
93	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	s:		1⊡Yes 2 X] No Sp	ecity:		Specify:	Black	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show ha Madical Examinar must be multied at	Completed	15. Decedent's			16a. Dece	dent's Usual C	occupation		elvie e	16b. Kind of Bus	siness/Industry	
21	Pin 7	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-4c	or 5+)	life.	kind of work of DO NOT use	retired)	j most or wo	rking			
2	gen th	on	12			M	anager				Fast Fo	od Restaura	nt
b	oth vent	Be (17. Father's Name (First, Middle, L.	ast)				18. 1	Mother's Na	me (First, Middle,	, Maiden Sumame	a)	
<u>a</u>	Aents Aents rkad tic e	To	Samuel H. Atkir	ıs					Jean :	Knight			
Maryland	shod Name		19a. Informant's Name/Relationshi	р (Туре, Print)		19b. Maili	ng Address (S	treet and N	lumber or R	ural Route Numbe	er, City or Town, S	State, Zip Code)	
Σ	alth alth		Samuel H. Atkins	s/ Father		6204	Sprin	ghill	Driv	e, #202,	Greenbe	lt, MD 2077	0
J.	trame itam	1 1	20a. Method of Disposition		20b. I	Place of Dispo	sition (Name	of or place)	Dec	Date ember 28	20c. Location - 0	City or Town, State	
Ē	Page H Co		1 ☑Burial 2 ☐ Cremation : 1 ☐ Donation 5 ☐ Other (Sp.			lenwoo		, ,,,,,,,		2004	Washing	ton. DC	
Baltimore,	parmit. Pages 1 and 2 should be filled within 72 hours after death with the Marylar Department of Health and Marital Hygiene. Department of Health and Marital Hygiene. Interportant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Experiment must be notified at any injury or other traumatic event, the Madical Experiment must be notified at once.		21. Signature PriFuneral Service Li			emeter	*	Address of			1 Home I		
ä	De par			Vo-		5	00 Uni	versi	ty Bl	d. W. E	ilver Sp	ring, MD 20	901
	500		23a. Part1. Enler He disease, or o shock, or heart failure. List o	omplications that caus	ed the deal							Approximate Interval Betwee	
68760,	Physician /Medical Examiner upon private priva	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	as a consec as a consec as a consec	quence of):	ultif	ole	inju	ries		Onset and Dea	
P.O. Box	es that the death certific igned by the attending p be detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition	23c. If yes, outcon 1	2 Feta at time of c	al death 3[death 5[Ectopic pregi Other (speci nderlying caus	ty)	Part I.		Mon	e of delivery th Day Year bute to the cause of deat	th?
orc	w requir been si should	ted								, ,	163 2 1140	JULI TODACIY 4 COURT	1104411
I Records,		Completed									osy pr ormed? de	fere autopsy findings avairior to completion of causi eath? □ Yes 2□ No	illable ie of
Vital	ding Physician: Th n. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?							ath (Check only o			
of \	Physic this o	2	1 Yes 2 No	Hospital: 1 Impa		ER/Outpatier	it 3□ DOA	Other: 4	☐ Nursing I	lome 5 ☐ Resid	dence 6 Othe	r (Specify)	
n c	ding P		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of In (Month,	Day Year)	28b. Time o Injury	28c.	Injury at Work?		28d. Describe	how injury occurre	Driver of	_ /
Division	Attending ir death. actor: After by the fune	Certification:	2.□Accident investiga	ition December	20	080	OM	1 🗌 Yes	2 No		3	" intersection	Por
Σį	for Attencation of Director:	tific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	286, Place of	Injury - At h	ome, farm, sti fy)	eet, factory, o	ffice		28f. Location (3 City or Tox	Street and Numbe vn, State)	r or Rural Route Number,	
	s aft	Cer			, ,	STV	eet			Elen 3	Dale, M.	myland	
	To the Hospital or Attent within 24 hours after death To the Funaral Diractor: completely filled in by the	Medical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the be xaminer: On the basis and manner	of examina	owledge, deat ation and/or in	n occurred at t vestigation, in	the time, da my opinion	ate and place n, death occi	e, and due to the urred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)	
	Vithi To tl	Σ	29b. Signature and title of certifier	, ,				icense num				(Month, Day, Year)	
)	i		Salvado	head.	er d	٥		How	5597	7 5	Decemb	2 23 200K	د
	6	1	30. Name and address of person w	h completed cause of	f death (Iter	n 23a) (Type,	Print)					7	
	1		Salvador Sylv	eter 30	x 150	spita	(Dri	ve.	Che	wk. 1	GANG /14	ev 23, 2006	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regi	strar's Sign	ature /	1	1		7/			
	Registi		DEC 28	2004	merchan	19	100	est					

			1 - For State Registrar	State o	f Marylar		artment of rtificate of	Health and N Death		ene . No. 20 () 4	42639
	Physici	an	1. Decedent's Name (First, Middle, Las-		- F11				2. Date of Death Month DECEMBER		(9 81,	3. Time of Death
,	/Media	cal	ROY DEAN 4a. Facility Name (If not institution, give		LEN		4b City Town	or Location of Death	1	4c. County of		11:30A M
	Examin	ier	NATIONAL LUTHERAN				ROCKVI			MONTGO		Y
	Funeral Director		5. Social Security Number 6. Se 209-10-2711	M 2 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Yea Months Days		8. Date of Birth Month, Day Y NOV 28,	915	PEN.	lace (State or Foreign
	land bw		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits
	e-f eh	ctor	MARYLAND MONTGOM	1ERY		RO	CKVILLE					Yes 2□No
	with the	Director	10e. Street and Number 9701 VEIRS DRIV	7E			10f. Zip Code	850	1	Citizen of Wh		of AMERICA
	death with the Maryland ms 23e or 28e-f show rmst be notified at	Funeral	11. Marital Status	12. Was Deci	edent Ever in U	J.S. 13. \		Hispanic Origin? (Sp ban, Mexican, Puerto		14. Race -	Americ	an Indian,
0000	urs after al', or Ite	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Fo 1 Tes If Yes, Giv Year or D	24 ∑ No ve	1	r Yes, specify Cu 1 ☐ Yes 2 ☐ No		Hican, etc.)	Specify:	White,	etc. ITE
5	72 hou	eted	15. Decedent's Ed (Specify only highest grad			16a. Deced	dent's Usual Occu	pation a during most of work ad)	king 16	b. Kind of Busi	ness/Inc	dustry
7	within iene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retir CLERK	ed)	1	OLESALE	DR	UG
ana	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or Items 23e or 28e-f show any injury operative treumatic event, the Medical Examinar must be notified at once.	Be C	17. Father's Name (First, Middle, Last) LEE ROY ALLEN					18. Mother's Nam	ne (First, Middle, Ma	iden Sumame)		
Mary	2 shoute and Me is mark eumatic	င္	19a. Informant's Name/Relationship (7)		ססיטי			et and Number or Rui				
e, e	1 and Health tem 27		DONNA A. ANDERSON 20a. Method of Disposition	- DAUG	20b.	Place of Dispo	sition (Name of	1		c. Location - Ci		
altimor	Pages nent of ant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ in a control of the control of a control of the con		State	•	natory`or other pl	12/2	8/04 FA	LLS CHU	IRCH	. VA
פשונ	permit. Departr Importe any inju		21. Signature of Funeral Service Licens	100		D_{A}^{22}	nzansky	GOLDBERG	MEMORIAL	CHAPEL,	IN	С.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cone cause on a	caused the dea			VILLE PIK ring, such as cardiac			<u>) 2</u> 0.	Approximate Interval Between
,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ARDIA		SRRHYT	ntias				Onset and Death
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	ed	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quence of):						
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9/00	cate be executed physician and the burial-transit	dlcal		dÇ	ACUE	D.C.					L.	
DOX O	es that the death certific igned by the attending p be detached for use as	Physician/Me	in the past 12 months?	1 ☐ Live b	tcome of pregn birth 2 Fet nant at time of	al death 3	Ectopic pregnan Other (specify)	су		23d. Date		ory Day Year
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ras, r	requires that been signed b hould be deta	by	Part II. Other significant conditions co	ntributing to d	eath but not re	sulting in the u	nderlying cause g	iven in Part I.				e cause of death? ably 4 □Unknown
Records,		ompleted							24a. Was an autopsy performe	prio	ere autop or to con ath?	psy findings available appletion of cause of
vitali	sicien: The taw s certificate has t irector, page 2 s	C	25. Was case referred to medical					26. Place of Deal	1 ☐ Yes 2 ☐		Yes	2□ No
5	ding Physicien: After this certific funeral director,	To B	TU TOS ZALINO		Inpatient 2			ther: 4 Nursing Ho	ome 5 🗆 Residenc			"
		tlon:	27. Manner of Death 1 🖄 Natural 5 🗆 Pending 2 🗀 Accident investigation	28a. Date (Mon	of Injury eth, Day Year)	28b. Time of Injury	W	uryat ork?]Yes 2. □No	28d. Describe how	injury occurred	ı	
JVISI	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	200. Flace	e of Injury - At h	nome, farm, str ify)	eet, factory, office		28f. Location (Stree City or Town, S		or Rura	l Route Number,
	hours a nerel l y filled		29a. Certifier 1 Certifying Phy	sician: To the	e best of my kn	owledge, death	occurred at the	time, date and place,	and due to the caus	se(s) and mann	er as st	ated.
	the Ho hin 24 the Fu	Medical	one)	and man	nasis of examin iner stated.	ation and/or in		opinion, death occur		. Date signed (
)	M W S		29b. Signature and title of certifier Nucleus	Bulle	~			051158		CEMBEY		
			30. Name and address of person who did	ompleted caus	se of death (Ite	m 23a) (Type,	Print)		LANTOWN	MAR	LYLI	CVM
	Sta		31. Date filed (Month, Day, Year)	32. F	Registrar's Sign	ature	Spork		1277 0 00 10			_
	Registi	ar	DEC 28 20	U4 /	energy	Fol	popular	2				

State of Maryland / Department of Health and Mental Hygiene 004 42640 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2004 porgen icht 2 0 Heven /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Bar Cambridge brches Mallard Care Cent If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 108 M 2 ☐ F 8. Date of Birth (Month, Qay, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 124-10-46 New Director York Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director Maryland Dorchester Cambridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with or Itams 23a Race Street 21613 USA Funeral 14. Race · American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 De No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ₺ No Baltimore, Maryland 21215-0036 Specify: Specify ģ 3 ₩ Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 ie marked other than any injury or other traumatic. Elementary/Secondary (0-12) College (1-4or 5+) Photography 11 <u>Photographer</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Emi1 Borgenicht Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Stephen Borgenicht/Son P.O.Box 5329 Salisbury Maryland 21802 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 2 Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 12-21-2004 Dover, Delaware 22. Name and Address of Facility
Bennie Smith Funeral Home
426 Dover Street, Easton, Maryland 21601 21. Signature of Funeral Service Licensee once 23a. Pertt-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chronic obstructive pulmonary /Medical Due to (or as e consequence of). **Examiner** physema Sequentially list conditions, any learned immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed the attending physicien and Due to (or as a consequence of): P.O. Box 68760 by Physiclan/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year į in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 2 No 1 Yes 2 **№** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier near HO05997 address of person who completed cause of death (Item 23a) (Type, Print) Johnson, 180 Bramble 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 21114

	1 - For State Registrar	State of N	Maryland	-	tment of I ificate of		d Mer		ene g. No. 2	004	1,2	61.1
isia	1. Decedent's Name (First, Midd	dle, Last)						Date of Death Month	Day	Year	3. Time o	Death
ysician Jedical	Harold	S.			lock				25	2004	6:40	AM
aminer	4a. Facility Name (If not institution		er)		4b. City, Town, o		ath			ity of Death		
	Springhouse at 5. Social Security Number		Age (In yrs. las	t birthday)	Beth If Under 1 Year		Irs. 8.	Date of Birth		ntgome		or Foreign
eral ctor	216-44-3169	1 X M 2□F	83	Yrs.	Months Days	Hours M	lin.	(Month, Day,) $g 7, 19$	Year) 921	MISS	olace (State ontry)	
	Usual Residence of Decedent 10a. State 10b. Count		100 000	Town or Loca							04 114: 0	4 . 4
or or			7								0d. Inside C 1 ☐ Yes	
Director	MARYLAND MONT	GOMERY	C	HEVY C	10f. Zip Code			106	g. Citizen o	f What Cour		X
I D	6412 RUFFIN RO	AD			208	15					d Stat	tes
Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S.	13. W	as Decedent of I Yes, specify Cub	Hispanic Origin?	(Specify	Yes or No-		ace - Americ		
other treumetic event, the Mudical Experiment burnelling at To Be Completed by Funeral Director	1 Never Married 2 Ma	rried 1 ☐ Yes 2 】	∑ No		Yes 2X No			, 5.6.,	Spec	cify:		
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event, Be C	17. Father's Name (First, Middle	, Last)				18. Mother's h	Name (F	rst, Middle, Ma	aiden Suma	ame)		
To	NATHAN	BLOCK				BERTH	-		WALKOV			
Ene	19a. Informant's Name/Relation				Address (Street				-			
thert	Gerald Cohen, 20a. Method of Disposition	Cousin	20b. Plac	The state of the s	stfield	Drive,	Wes			10 T 1 n - City or To	63131	
di	1 ☑ Burial 2 ☐ Cremation		te cern	netery, crema	itory or other pla							
any Injury or other tr	`4 □Donation 5 □Other (CHE		IEL EMET Name and Addre		29/2	004 UI	NIVERS	SITY C	ITY, I	10
any Ir once	1	to the	,	Dan	nzansky- () Rockv	-Goldber	g Me	morial	Chap	els, 1	Inc.	
the burial-transit range last last last last last last last last	23a. Part1. Ever the disease shock, it heart failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, take the cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Conges Due to (or a b. Chroni Due to lor a c. Gout	stive H as a consequer LC Rena as a consequer as a consequer	eart F nce of): 1 Fai1 nce of):	ailure						Onset and	Death
detached for use as the but Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal de at time of deat	eath 3□E	ctopic pregnanc Other (specify) _	у			-	Pate of delive	,	∕ear
p p	Part II. Other significant condit	ti ons contributing to death	but not resulti	ing in the und	lerlying cause gr	ven in Part I.		23e. Did toba		ntribute to th		
Completed								24a. Was an	246	. Were auto	psy findings	available
Comp							_	autopsy performe	ed?	death?		ause or
stor. p	25. Was case referred to medic examiner?	al				26. Place of I	Death (C	neck only one)				
	1 Yes 2X No	Hospital: 1 ☐ Inpa		VOutpatient	3 DOA		-	5 🗌 Residen				
To B	00 11	ing 28a. Date of Ir	njury 21 Da <i>y Year)</i> 21	8b. Time of Injury	28c. Inju Wo		28d.	Describe how	v injury occi	urred	Livin	g
on: To E	27. Manner of Death 1 X Natural 5 ☐ Pend				M 1	Yes 2 □No		1	not and Nun		I Poute Num	ber,
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Medical Certification; To E	1 Natural 5 Pend inves 3 Suicide 6 Coulc 4 Homicide deter	d not be mined 28e. Place of building, ing Physician: To the be at Examiner: On the basis and manner	etc. (Specify) st of my knowle	edge, death o	occurred at the ti	opinion, death o	ace, and	City or Town, due to the cau t the time, date	State) use(s) and read place	manner as st	ated. the cause(s)
led in by the Certificat	1 X Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifler (Check only one) 1 X Certify 2 Medica	d not be mined 28e. Place of building, ing Physician: To the be at Examiner: On the basis and manner tier £. Carray	etc. (Specify) st of my knowle of examination stated.	edge, death on and/or inve	29c. Licen:	opinion, death o	ace, and	City or Town, due to the cau t the time, date	State) use(s) and read place	manner as st	ated. the cause(s)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Phyllis Esther Month Year Ronner 10:15 AM December 20 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) March 22,1921 6. Sex Birthplace (State or Foreign Country)
 PA **Funeral** Days Hours Min. 1 □ M 2 🗓 F 179-18-1405 83 Yrs. Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other treumstic event. The Mudical Examinary ust be notified at Director Chesterfield 1 ☐ Yes 2 X No Midlothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4204 Northwich Road 23112 Items 23a United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If filem 27 is marked other than "neturel", or Item any injury or other treumatic event. The Medical Exempted page. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 🛣 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) State Government Elementary/Secondary (0-12) College (1-4or 5+) Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Dowling Kathryn Knox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Barlow/Son-in-law 4204 Northwich Road, Midlothian, VA 23112 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State December 23 Chesterfield, VA `4 □ Donation 5 🖔 Other (Specify) Entombment Dale Memorial Park 22. Name and Address of Facility DeVol Funeral Home, 10 Deer Park Drive, Gaithersburg, MD 20877 21. Signature of Funeral Service Licensee بروس بن 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Cardiac Arrest /Medical Due to (or as a consequence of) **Examiner** Pnenomia Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Acute M eloc tic Leukemia physician ar s the burial-tr Due to (or as a consequence of): Box 68760 Physiclan/Medical Thrombocytopenia attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐ Pregnant at time of death Month Dav Year 5 Other (specify) Division of Vital Records, P.O. the ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anemia 1 X Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? Yes 2 No 1 Yes 1 Tes 2□ No To the Hospitel or Attending Physicien: within 24 hours after death.
To the Funerel Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 N Inpatient 2 SP/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and Little of certifier 29d. Date signed (Month, Day, Year) 00054843 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 Medical Center Drive, Rockville, MD 20850 David A. Charles, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 28 2004 25 gast As Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month BRIGHT 24, MARGARET BOWERS DEC. 2004 7:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15300 PINE ORCHARD DR. #26 SILVER SPRING MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 💢 F Yrs Director 220-07-9201 86 JAN 8, 1918 MARÝLAND Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or items 23e or 28a-f show treumatic event, the Madical Examiner must be notified at Director 1 X Yes 2 □ No MONTGOMERY MD. SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Items 23e 15300 PINE ORCHARD DR. #26 20906 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 À 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE AGENT REAL ESTATE SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CLAIDE BOWERS **EDNA** DAVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health an DONALD S. BRIGHT/SON 800 HOSPITAL DR., SUITE #7, NEW BERN, N.C. 28560 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of It Important: If ite 1 ☐ Permoval from State
1 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEMETERY 12-30-2004 BRENTWOOD, MD. 21. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a END STAGE CONGESTIVE HEART FAILURE YEARS /Medical Due to (or as a consequence of) Examiner AORTIC VALVE STENOSIS YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Box 68760 Physician/Medical IF FEMALE esn. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has autopsy performed Division of Vital 1 Yes 2 X No 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death Check onl one examiner's Other: 4 Nursing Home Testidence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 28d. Describe how injury occurred Certification: After 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D43202 DEC. 27, 2004 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20906 CHARLENE OZANNE-BLANKFARD, M.D. 3305 N. LEISURE WORLD BLVD., SILVER SPRING, MD. 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature DEC 28 2004 Registrar

			1 - For State Registrar	State of Ma	ryland / Depa	artment of H	lealth and N	lental Hygie	•		
	Physic	ian	Decedent's Name (First, Middle, Last	1)				Date of Death Month	Day Yea	3. Time of Death	
	/Medi		ALBERT FREDE		BLACHER			DECEMBER	21, 200		
	Examir	ner	4a. Facility Name (If not institution, give	street and number)			Location of Death		4c. County of De		
			BEDFORD COURT		//	SILVER S			MONTGO		
т	Funeral Director		5. Social Security Number 6. Se	X 7.Age ZIM 2□F	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		irthplace (State or Foreign Country)	
			578-14-8170		88 Yrs.			MAR 9, 1	916 WA	SHINGTON, DC	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importents: If item 27 is marked other than "naturel", or itams 23a or 28e-f show importents: If item 27 is marked other than "naturel", or itams 23a or 28e-f show injury cother treumatic event, I're Madical Examinar must be muilted anone.	tor	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits	
			MARYLAND MONTGOME	RY	SILVER	SPRING				1 ☐Yes 2 ☐ No	
		rec	10e. Street and Number	10f. Zip Code		10g	. Citizen of What	Country?			
		O E	1131 UNIVERSITY BLVD., WEST #1419 20902 UNITED STATES						ATES		
		Funeral Directo	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of Hi f Yes, specify Cuba			14. Race - Ar	nerican Indian,	
9			1 ☐ Never Married 2 X Married	1 X Yes 2 ☐ No	0			Hican, etc.)	Black, Wi	nite, etc.	
5-0036		Completed by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: WWII					Specify: WHITE			
5-		ete	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Deced	dent's Usual Occupa kind of work done d DO NOT use retired,	ation Juring most of work	ina 16	b. Kind of Busines	s/Industry	
121		μ	Elementary/Secondary (0-12)	College (1-4or 5-	-) !) *				
121			12 17. Father's Name (First, Middle, Last)		SAL	ESMAN	40 11-1-1		WOMEN'S	SHOES	
anc		Be		CHED				e (First, Middle, Ma	,		
Š		은		CHER		1120	ROSLEINI		HYMAN		
Maryland			19a. Informant's Name/Relationship (T)	•						. Zip Code) 20902	
	1 and Healt em 2 ther		FRANCES W. BLACHER 20a. Method of Disposition	, WIFE						SPRING, MD	
آور	0/5 = 5/V		1 XBurial 2 ☐ Cremation 3 X F		20b. Place of Dispo cemetery, cren		1		c. Location - City of		
Baltimore,	rtmer rtent njury		`4 □ Donation 5 □ Other (Specify)				-11			RCH, VIRGINI	
Ba	permit. Departn Importe eny inju		21. Signature of Funeral Service Licens	h Shi	D. 1	Name and Addres ANZANSKY- 170 ROCKV	GOLDBERG LLLE PIKI	MEMORIAL L, ROCKVI	CHAPELS LLE, MD	, INC. 20852	
			23a. Part1. Inter the dise, ir compleshoot, or heart failur I. Li it only o	lic flions that caused t ne cause on each line	he death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arrest		Approximate Interval Between	
	Physician /Medical Examiner		Immediate Cause (Final							Onset and Death 6 months	
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		iner	f any, leading to immediate cause. Enter Underlying Cause (Disease on injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
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9	death certifica attending ph d for use as th	Physician/Medlcal	IF FEMALE:								
Box	ath or ttend or us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o 1 ☐ Live birth 2	Fetal death 3	Fetal death 3 Ectopic pregnancy				23d. Date of delivery Month Day Year	
0	law requires that the cas been signed by the 2 should be detached	sici	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown						Month	Month Day Year	
Ρ.		Phy	Part II Other significant conditions contribution to death but not condition in the second se								
S		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown								
orc		etec						2 No 3 Probably 4 Unknown			
Records,		Completed	Aspiration Pneumonia					24a. Was an autopsy findings prior to completion of		completion of cause of	
	Th ate pag	Cor					performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No				
Vital	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Be	25. Was case referred to medical examiner?	12-1				(Check only one)			
of		P	TE THE ZENO	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA			r: 4 🛚 Nursing Ho	me 5 🗆 Residence	5 Residence 6 Other (Specify)		
		on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Work? M 1 ☐ Yes 2 ☐ No		28d. Describe how injury occurred			
		Certification;	2 Accident investigation 3 Suicide 6 Could not be								
Ξ		Ħ	4 Homicide determined				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	urs a										
	To the Hospitel within 24 hours a To the Funerel C completely filted	Medical	29a. Certifier (Check only one) 29a (Datifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To the within To the Comp	Σ	29b. Signature and title of Satisfier 29d. License number 29d. D					Date signed (Month, Day, Year)			
1 Mind 21 7 Mg TO 051							5120	DECEMBER 23, 2004			
-	(V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
			MICHAEL EMMER, M.D., 6316 DEMOCRACY BLVD., BETHESDA, MARYLAND 20814								
	Sta	te	31. Date filed (Month, Day, Yedr)	32. Registrar	's Signature					76	
	Registr	ar	DEC 28 200	14 Jenes	par B	Sparks					

State of Maryland / Department of Health and Mental Hygiene 200442645 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Lillian C. Biller December 26, 2004 4:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9039 Sligo Creek Parkway #206 Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🗑 F Yrs. Director 579-50-6922 67 11/15/1937 New Hampshire Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location in than "natural", or Itams 23a or 28e-f show 10d. Inside City Limits Director Silver Spring 1 X Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 9039 Sligo Creek Parkway #206 Funeral 20901 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by Specify: White 3 Widowed 4 XDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than eny injury or other traumatic event. Its M. Elementary/Secondary (0-12) College (1-4or 5+) AWONN Editor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 9 Harry Loftus Kathleen Irene Dressler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 161 Orchard Street, Chelsea, Michigan 48118 Harry Biller, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Crematory 12/30/2004 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Glioblastoma 10 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 autopsy performed? 1 ☐ Yes 2**∑** No 1 Yes 2**X** No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 ☐ Yes 2X No 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; 28d. Describe how injury occurred Injury 1 X Natural 1 ☐ Yes 2 ☐ No investigation after death 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 To the 29d. Date signed (Month, Day, Year) D33159 December 27, 2004 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ruth Kevess-Cohen, MD, 8700 Georgia Ave. #400, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 28 2004 Registrar

			1 - For State Registrar	State of Maryland /	Depa	artment of hartificate of	lealth and	Mental Hyg	iene 20	04 4264
	Physic /Medi		Decedent's Name (First, Middle, Last,	Stanley	В	ARBAN				3. Time of Death 04 2:35 A M
	Examir	ner	4a. Facility Name (If not institution, give				r Location of Deat	h	4c. County of	
	Funeral	-	Hebrew Home of G. Social Security Number 6. Securit	7. Age (In vrs. last bi		Rockv	If Under 24 Hrs	8. Date of Birth		gomery Birthplace (State or Foreign
	Director		051-12-9841 Usual Residence of Decedent	IM 2□F 83	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, March 1	6, 1921	New York
	a-f ehow	ctor	Maryland Montgom	ery B	ethe					10d. Inside City Limits 1 ☐ Yes 2 X No
	with the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	,
	heath	Funeral	6603 Pyle Road	12. Was Decedent Ever in U.S.	13 1		20817	Decity Vos er No	United	States American Indian,
	urs after o al', or Iten	þ	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW TT		Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl Specify:	o Rican, etc.)	Black,	White, etc. white
200	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. dother than "natural", or items 23a or 28s-f ehow event, Lie Medical Exeminer mala be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16a	Deced (Give life, E	ent's Usual Occup kind of work done OO NOT use retired	ation during most of world)	king]		Institutes
4	filed with Hygien of ther the ent.	S	17. Father's Name (First, Middle, Last)	5+	Bioc	hemist			of Healt	II
	permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic even	To Be	Isido	e Barban			Pauli	ne (First, Middle, M ne Wagnet	r	
2	od 2 st lith and 27 ie n r traun		19a. Informant's Name/Relationship (Ty) Barbara Barban, Wii				and Number or Ru , Bethes	ral Route Number, da. MD 2	City or Town, Sta 20817	ite, Zip Code)
Daltillole,	of Head of Head if item		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R	20b. Place of		sition (Name of atory or other place			20c. Location - Cit	y or Town, State
	rant:		' 4 ☐ Donation 5 ☐ Other (Specify)	Judean		orial Ga	rdens		Olney, N	MD
2	Depa Impo any i		21. Signature of June all Service Cleense		To	rchinsky	Hebrew	Funeral H	Home	
	Physician /Medical Examiner	ner	23a. Par(1. Ther the disease, or complished, of heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury	Due to (or as a consequence	of):	ir the mode of dyin	g, such as cardiac	of respiratory arre	st,	Approximate Interval Between Onset and Death
	eain certificate be executed attending physician and for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):					
í	0 0 0	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Ic. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
60000	ine law requires mat me ate has been signed by th page 2 should be detache	by P	Part II. Other significant conditions con	ributing to death but not resulting in	n the un	derlying cause give	en in Part I.		_	te to the cause of death?] Probably 4 @Unknown
	as bee	mpleted						24a. Was an		autopsy findings available to completion of cause of
í		ပိ						perform	ed? deat	h? Yes 2 No
	certif	o Be	25. Was case referred to medical examiner?	ospital:		Othe		h (Check only one		
	After this funeral d	\vdash	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 28b. 3	itpatient Time of njury	28c. Injury Work	at	ome 5 Resider 28d. Describe how	oce 6 Other (5 v injury occurred	Specify)
	within 24 hours after death, To the Funeral Directors After this certific completely filled in by the funeral director,	Certification:	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, stre		3.0	28f. Location (Stre City or Town,	eet and Number of State)	r Rural Route Number,
	Funer Funer Tely fill	Medical	29a. Certifier 1 Certifying Phys. (Check only one) 2 Medical Examin	cien: To the best of my knowledge er: On the basis of examination and	death	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the car	use(s) and manne	r as stated. due to the cause(s)
	vithin (Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	29	d. Date signed (M	onth. Dav. Year)
,	Ω		1 Jany 3 W.	UE-		D5	5258	1	P/2. /	76 2004
	0		30. Name and address of person who con	npleted cause of death (Item 23a) ((Type, P	rint)	0.1.	1- M	/ 1 >	152
(h)	Sta	e	31. Date filed (Month, Day, Year)	32. Begistrar's Signature	Nou	Roud	Machill	10 /king	lad la	3
	Registra	-	DEC 28 2004	Denewar /	9	Spants				

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #8 PER FH C846 8/24/05 TH Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 543 P M Césarini OSeph 8 Dec 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical M Baltimore Baltimore (Center 110 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1928 Month, Day Year NOV 18 1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 PA **Funeral X**□M 2□F Months Days Hours Min 86 Director 195-24-3037 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits itsm 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2√2 No Director MD CAROLINE RIDGELY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24561 BURNT MILL ROAD 21660 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. I important: If Item 27 Is marked other than "natural", or Item any injury or other traumatic avant the 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER LANDSCAPE NURSERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 GABRIEL CESARINI GIUSEPPINA CHUMPA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSANNA CESARINI/WIFE PO BOX 372 RIDGELY, MARYLAND 21660 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 12-20-2004 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Joseph M. C.F.S.P. Ostrusk. 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician staph aureus days /Medical Due to (or as a consequence of): **Examiner** rena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit physician and Due to (or as a consequence of): Box 68760, Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 70 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation M 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and tylle of contifier 29d. Date signed (Month, Day, Year) 29c. License number 15813 Dec 18, 2004 Wille ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr. MI Greene St LUMPKINS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 1 2004 Registrar

				partment of Health and Mertificate of Death	lental Hygie	_	42648
	Dhamini		Decedent's Name (First, Middle, Last)		2. Date of Death	Davis	3. Time of Death
	Physici /Medi Examir	cal	VIRGINIA N. CRAWFORD 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	December	Day Year 26, 2004 4c. County of Dea	3:00P M
	LXuiiii	ic.	Manor Care Nursing Home	Silver Spring			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgome 9. Bir	
и	Director		416–28–9003 1□M 2\F 81 Yrs.	Months Days Hours Min.	B. Date of Birth (Month Day, Y) Feb. 14, 1	923 Ala	thplace (State or Foreign buntry) bama
	pu ,		Usual Residence of Decedent				
	e-f show	ctor	Maryland Montgomery 10c. City, Town or Silve	Location r Spring			10d. Inside City Limits
	be filed within 72 hours after death with the Maryland stal Hygiene. ad other than "neturel", or items 23a or 28e-f show event. The Madical Examinar must be notified at	al Director	10e. Street and Number 2501 Musgrove Road	10f. Zip Code 20904	_	Citizen of What Co	•
	ems arms	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
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and	be fi	Be	17. Father's Name (First, Middle, Last) Brainard H. Nunnelley	18. Mother's Name Myrtle	(First, Middle, Mai	iden Sumame)	
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Maryland	permit. Pages 1 and 2 should b Department of Health and Ments Importent: If item 27 is marked eny injury or other treumetic e once.		19a. Informant's Name/Relationship (Type, Print) 19b. Ma Carol Romer –Daughter 150	ling Address (Street and Number or Rura	l Route Number, C	ity or Town, State, 2	(ip Code)
	1 and Healt em 2 ther	1 3	20a Mathad of Disposition 20h Place of Dis	Northcrest Drive			
Baltimore,	do = 30		1 X Burial 2 □ Cremation 3 □ Removal from State George	matery or other place) Cem. 12/3	31/2004 A	c. Location - City or delphi M	lown, State
臣	it Printing		0 1				
Ba	Depariment of the permit of th		21. Signature of Funeral Service Licenty e	22. Name and Address of Facility Onald V. Borgwardt 400 Powder Mill Roa	Funeral	Home. P.A	
			220 Part I Enter the disease or complications that several the death December 1	400 Powder Mill Roa	ad Beltsv	ille, Mar	vland 20705
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		r respiratory arrest,		Approximate Interval Between Onset and Death
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Вох	death certifical e attending phi of for use as th	/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			22d Date of delli	
ă	atter atter	ciar	in the past 12 pronths?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deli Month	Day Year
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	that		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
Vital Records,	law requires that the as been signed by th 2 should be detache	d by	Severe chronic lung disease; steopo	rosis	1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknown
S	w rec	lete			24a. Was an	24h Wara au	opsy findings available
Re	0 5 0	ompleted			autopsy	/ prior to c	ompletion of cause of
g	iicien: Th certificate rector, pag	Ö	25. Was case referred to medical		1 Yes 2	No 1 ☐ Yes	2 No
>	ysicien: is certific director,	o B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	26. Place of Death			
of	Phys er this eral di	\vdash	27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at 2	8d. Describe how in	6 Other (Spec	ify)
0	th: Afte	t o	1 Vatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		,,	
Division	ol or Attending Physicien: after death. I Director: After this certific d in by the funeral director,	fice	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s	treet, factory, office 2	8f. Location (Street	t and Number or Ru	al Route Number.
á	i i ii i	Certification:	4 ☐ Homicide building, etc. (Specify)		City or Town, St		
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, a	nd due to the cause	e(s) and manner as	stated.
	he Hi n 24 he Fu	edical	(Check only one) 2 Medicel Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurre	d at the time, date	and place, and due	to the cause(s)
	withii To th	Ň	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	Day, Year)
			Kaman K. Twoi	D19609	12	27.04.	_
	B		30. Name and address of person who completed cause of death (Item 23a) (Type				
			Raman R. Tuli, M.D. 3503 Perry St.,		vland 20	712	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Sports	,		
	Registr	ar	DEC 28 2004 Server 19	ypours			

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month Physician Year John Albert Cullen December 25, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3314 Chiswick Court, #2E Silver Spring Mor If Under 24 Hrs. Hours Min. Hours Min. Month, Day, Year) April 30, 1923 Montgomery If Under 1 Year 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 12 M 2 □ F 145-18-6548 Yrs. 81 Director New Jersey Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits r then "natural", or items 23e or 28e-f show the Medical Examinar must be notified at Maryland Director 1 ☐ Yes 2 ☑ No Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3314 Chiswick Court, Funeral 20906 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give T Baltimore, Maryland 21215-0020 1 ☐ Yes 2 A No Specify: White Completed by Specify: WWII 3 □ Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Municipal Government Firefighter permit. Pages 1 end 2 should be file.
Department of Health and Mental Hy.
Important: If item 27 is marked othe any injurygrother traumatic everages. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Cullen Anna Siebel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Theresa Cullen/ Wife 3314 Chiswick Court, #2E, Silver Spring,MD 20906 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dec 29 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jersey City, New Jersey Holy Name Cemetery 2004 P2. Name and Address of Facility Francis J. Collins Funeral Home Inc 21. Signature of Funeral Service Licensee 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the Seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ACUTE MY UCARDIAL INFARCTION 1 mme DIME Examiner Due to (or as a consequence of): DISE A3E Hypertensive Hemi 12 years or Attending Physician: The law requires that the death certificate be executed Exami Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown δ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation s after dea. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after
To the Funeral Dirac 4 Homicide 29a. Certifier (Check only one) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To tha 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December 27, 2004 Im a Rmi 1)24143 30. Name address of person who completed cause of death (Item 23a) (Type, Print) 3305 NONTH Leibure WORLD BLVD., SILVER SPRING MO 2090 James A. Rossimo 31. Date filed (Month, Day, Year) 33. Registrar's Signature State DFC 28 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 31,2004 1112 AM Necomber John Wesley Corkell, Jr. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Easton Easton Memorial Hospital Talbo If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 XM 2 ☐ F Yrs. Director 217-36-03 20 80 February 17, 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits Itam 27 is marked other than "netural", or Items 23a or 28a-f show other traumatic avant. The Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Be Completed by Funeral Director Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of 28089 Anthony Mill Road 21629 <u>America</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ies 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. If Itam 27 is marked other than "netural", or Ite 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Caucasian Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Farmer Farming 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ٥ Ada Louise Hammond John Wesley Corkell, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28089 Anthony Mill Road, Denton, Maryland 21629 Katherine Corkell Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department of Important: If any injury or Denton Cemetery 1/5/2005 Denton, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 2. Sign dur of Funeral Service Licens 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 lock 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** acute myocardia minutes /Medical **Examiner** oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit Hospital or Attanding Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an director, page 2 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ► R/Outpatient 3 DOA Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled within 24 hours a

To tha Funaral C

completely filled i Exertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0047534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

fords)

Wafik Zaki, M.D., 920 Market Street, Denton, Maryland 21629

32. Registrar's Signature

		For State Registrar	State of	Maryland / D	Depa	rtmen	t of H	ealth a	and M	lental Hyg	giene Reg. No.	201) [4	4265
Physicia /Medic		1. Decedent's Name (First, Middle, t Gerald Edgar Dou	ıb			th City	Town	Landing	of Dooth	2. Date of Dea Month Dec.	3(20 County of		3. Time of Death 08:10 A M
Examin		4a. Fecility Name (If not institution, s Clearview Nursing 5. Social Security Number 6	ng Home	nber) 7. Age (In yrs. last birl		Hage	rsto	Location of WIN		8. Date of Birti	Wa	shin	gto	n plece (State or Foreign
Funeral Director		215-14-2800 Usual Residence of Decedent	1 ∑ M 2□F	89	Yrs.	Months	Days	Hours	Min.	8. Date of Birt Month, Dat 08/31/I	915			MD
e Marylen 8a-f ehow	ctor	MD Washing	gton	10c. City, Town		m								10d. Inside City Limits 1 ∑XYes 2 ☐ No
ith with th	al Dire	10e. Street and Number 7 E. Washington	Street				740				U			
Baitimore, Maryland 21215-0036 permit. Pages I and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth end Mentel hygiene. Important: If Item 27 is marked other than "naturel", or Iteme 23s or 28s-1 show eny injury or other treumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed For	2.PŠNo e				spanic Ori n, Mexicar Specify:		ecify Yes or No- Ricen, etc.)		14. Race - Black, Specify:	White,	
21215-0036 d within 72 hours at giene. ar then "naturel", or the Madical Exam.	ompieted	15. Decedent's (Specify only highest to Elementary/Secondary (0-12)	Education grade completed) College (1		Decede (Give k life. D	ent's Usua kind of wo PO NOT u Farm	rk done d se retired	ation during mos)	t of work	ing	16b. Ki	nd of Busin		
Maryland 2 and 2 should be filed the end Mentel Hyg 27 is marked other treumatic event.	To Be C	17. Father's Name (First, Middle, La Mason W. Doub	st)							e (First, Middle, ace Spes		_		
Mary Ind 2 shou eith end h		19a. Informant's Name/Relationship Ronald A. Doub,		P	. 0.	. Вох	528	s, Sh	er or Run ipper	al Route Numbersburg,	PA	17257	ate, Zip	Code)
Baitimore, bermit. Pages 1 at Depertment of Hee mportant: If them any injury or othe anges.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		State Rose H) 2004		cation - Ci	-	
Balti permit. Depertm imports eny inju		21. Signature of Funeral Service Lice	1-76	2	1 30	05 N.	Pot	ss of Facili	Str	eet, Has	gers			eral Home 21740
Physician /		23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	CH			er the mod	de of dyin	g, such as	cardiac	or respiratory ar	rest,			Approximate Interval Between Onset and Beath CMONIC
Examiner		Sequentially list conditions,	Is	chemic Consequence of as a consequence	av di	i'o mg	opa	thy						chanic
760, te be executed ysicien and te buriel-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Adi	or as a consequence	ma	7)	105 f	ate :						34Ns.
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COTGS, P. w requires that is been signed by	d by Ph	Part II. Other significant condition	s contributing to de	eath but not resulting in	n the un	derlying	ause give	en in Part I			obacco u res 21			he cause of death? pably 4 Unknown
of VITAL RECORDS, hysician: The law requires the cartificate hes been signed idirector, pege 2 should be controlled.	omplete											prid dea	re auto or to co ith?] Yes	opsy findings available impletion of cause of
of Vita Physician: this certifice rel director, I	Be	25. Was case referred to medical examiner?	Hospital:	npatient 2 ER/Ou	itnatient	3 □ D	Oth			h (Check only o		S ∏Other	(Specii	(v)
0 2 3 6	ation; To	27. Munner of Death Natural 5 Pending 2 Accident investiga	28a. Date (Mont	of Injury h, Day Year) 28b. 1	Time of njury	M	28c. Injun Work 1 🔲			28d. Describe h	now injur	y occurred		
Division To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could no determin	200. Flace	of Injury - At home, fa ng, etc. <i>(Specify)</i>	ırm, stre	et, factor	y, office			28f. Location (S City or Tox			or Rur	al Route Number,
the Hosp in 24 hou the Funel spletely fil	Medical	(Check only 2 Medical Ex	caminer: On the ba	best of my knowledge asis of examination an ner stated.		estigation	n, in my o	pinion, dea		red at the time,	date and	place, and	due t	o the cause(s)
with To Con	2	- 17	-: HD					9 number	123		290. Dai	$\frac{130}{t}$		Day, Year)
SH-2		Praveen Balarum	340 Mil	1 Street,			own,	MD 2	174 0			.355		
Sta Registi		31. Date filed (Month, Day, Year)	4 2005 32. R	egistrar's Signature	Po	perte						-		

DHMH 17 Rev 1/2001

Director Usual Residence of Decedent 10a. State 10b. County MARYLAND MONTGOMERY 10c. City, Town or Location CHEVY CHASE 10c. Street and Number 8100 CONNECTICUT AVENUE, #414 20815 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 11. Was Decedent Ever in U.S. Amed Forces? 11. Was Decedent Ever in U.S. Amed Forces?	Hrs. 8. Date of B	BER 22, 2004 12:50 A 4c. County of Death MONTGOMERY Birth Pay, Year) 1915 9. Birthplace (State or Formula) MASSACHUSETT 10d. Inside City Li 1 Xes 2 C 10g. Citizen of What Country? UNITED STATES	M
Funeral Director SUBURBAN HOSPITAL 5. Social Security Number 010-03-9630 Usual Residence of Decedent 4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Mo	Hrs. 8. Date of B	MONTGOMERY 9. Birthplace (State or Formally), 1915 MASSACHUSETT 10d. Inside City Line of What Country? UNITED STATES	reign
Funeral Director 5. Social Security Number 0.5 Security Number 0.5 Security Number 0.7 Age (In yrs. last birthday) 0.7 Age (I	in. JULY	9. Birthplace (State or For Country) 9. Birthplace (State or For MASSACHUSETT) 10d. Inside City Li 1 X Yes 2 [10g. Citizen of What Country? UNITED STATES	reign
Director 010-03-9630 1 M 2 T F 89 Yrs. World's Days Hours		10d. Inside City Li 1 X Yes 2 [10g. Citizen of What Country? UNITED STATES	TS.
	? (Specify Yes or N uerto Rican, etc.)	1 TYPS 2 TO 10g. Citizen of What Country? UNITED STATES	
MARYLAND MONTGOMERY CHEVY CHASE 106. Street and Number 107. Zip Code 8100 CONNECTICUT AVENUE, #414 20815 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation	? (Specify Yes or Nuerto Rican, etc.)	10g. Citizen of What Country? UNITED STATES	imits
10e. Street and Number 10f. Zip Code 20815 10e. Street and Number 8100 CONNECTICUT AVENUE, #414 20815 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation	? (Specify Yes or Nuerto Rican, etc.)	UNITED STATES]No
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15. Decedent's Education 16a, Decedent's Usual Occupation		Specify: WHITE	
(Specify only highest grade completed) (Give kind of work done during most of	workina	16b. Kind of Business/Industry	
Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER	g	OWN HOME	
D = 17. Father's Name (First, Middle, Last) 18. Mother's 1	Name (First, Middle	le, Maiden Surname)	
The state of the s	ERTRUDE	FEINBERG	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of			
EDWARD B. DOSIK, SON 11221 KORMAN DRIVE, 1	Date	MD 20854 20c. Location - City or Town, State	
1 X Burial Cremation 3 X Removal from State (Semetery, crematory or other place) 1 X Burial Cremation 3 X Removal from State (Semetery, crematory or other place) 1 X Burial Cremation 3 X Removal from State (Semetery, crematory or other place)	23/2004	FALLS CHURCH, VIRGI	NIA
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23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.		arrest, Approximate Interval Between	
Immediate Cause (Final disease or condition resulting in death) PNEUMONIA		Onset and Deat	n
/Medical resulting in death) Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying. Due to (or as a consequence of):			
if any, leading to immediate cause. Enter Underlying Cause (Olts as a reflict) that initiated events resulting in death) Last Due to (or as a consequence of): C			
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Sproops and the state of the st		23d. Date of delivery Month Day Year	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contribute to the cause of death	1?
INTERSTITIAL PULMONARY FIBROSIS	_ 10	Yes 2 No 3 Probably 4 Winkin	own
mpie	24a. Wa auto	opsy completion of cause death?	able of
T p w d O O O O O O O O O O O O O O O O O O	1 ☐ Yes	2MNo 1 ☐ Yes 2 ☐ No	
examiner? A Second Seco	Death (Check only) g Home 5 Res	sidence 6 Other (Specify)	
27. Manner of Death 28a. Date of Injury 28b. Time of 1 Minuty 28c. Injury 28c.		e how injury occurred	
INTERSTITIAL PULMONARY FIBROSIS INTERSTITIAL PULMONARY FIBROSIS INTERSTITIAL PULMONARY FIBROSIS INTERSTITIAL PULMONARY FIBROSIS 26. Place of 10 pl	28f Location	(Street and Number or Rural Route Number,	
27. Manner of Death 1		own, State)	
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placed in the control of the control	ace, and due to the courred at the time	e cause(s) and manner as stated. e, date and place, and due to the cause(s)	
29b. Signature and title of certifier 29c. License number	21	29d. Date signed (Month, Day, Year)	
DOOG16	31	12-22-04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELAINE M. SLOAND, M.D., 8600 OLD GEORGETOWN ROAD, BI	ETHESDA.	MARYLAND 20814	
State Registrar State Registrar			

			1 - State of Maryland / Depa State Registrar Cert	rtment of Health and M	lental Hygie	-	42653
П	Physic	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	Salvatore D'Amato		December	26, 2004	1:35 PM
1	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
	Funeral		Montgomery General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Olney If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgo:	
	Director		091-10-5955 ^{№ 2□F} 84 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye March 20,]		nplace (State or Foreign Intry) taly
	D >		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Loc				
	shov	5					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	28a-f	Director	Maryland Montgomery Silver S		40-	Cities (1997)	
	With Ba or		14556 Kelmscot Drive	10f. Zip Code	10g.	Citizen of What Cou	intry?
	death ms 2:	Funeral		as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	city Yes or No-	USA 14. Race - Amer	ican Indian.
9	or Ita	Fur	1 Never Married 2 La Married 1 La Yes 2 No	V	Rican, etc.)	Black, White	
003	d within 72 hours after death with the Maryland Jene. Ir than "natural", or Itams 23a or 28e-1 show The Medical Examone founds be pruffled at	d by	3 Wildowed 4 Divorced Year or Dates: 1942-45	☐ Yes 2 No Specify:		Specify:	200
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12	within ene. than	duic	Elementary/Secondary (0-12) College (1-4or 5+)				
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lan	fental fental rked tic ev	To Be	Ciro D'Amato		a Porcell	,	
Maryland 21215-0036	and Mana			Address (Street and Number or Rura	l Route Number, Ci	ty or Town, State, Zi	p Code)
	and 2 ealth n 27 i		Maria D'Amato/ Wife 14556	Kelmscot Drive,	Silver Sp	pring, MD	20906
altimore,	permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other t any injury poether traumatic event. In once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	tion (Name of December place)	ate 20c	. Location - City or T	own, State
ţ	tant:		'4 □Donation 5 □Other (Specify) Gate of Hear	ven Cemetery 2004	Si	lver Spri	n, Marylan
Bal	Department of the post of the		21. Signatur of Funeral Service Lyen see	Name and Address of Facility ancis J. Collins	Funeral H	Home Inc.	3677 (2004 (3607)
			23a. Part V Enter the disease, or complications that caused the death. Do not enter	O University Blvd	. W., Sil	ver Sprin	g. MD 20901
	Dhuaisian	8 17	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	the mode of dying, such as cardiac o	respiratory arrest,		Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death) a. P.O.F.A.TE CAN Due to (or as a consequence of):	CER			3 YEARS
į.	Examiner						
	p =	iner	if any, leading to immediate Due to (or as a consequence of):				4
	and trans	Examiner	Cause (uisease or irijus) that initiated events resulting in death) Last Due to for as a consequence of the				
8760,	icate be executed physician and s the burial-transit		Due to (or as a consequence of):				
687	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medical	d				
Box (that the death certific ed by the attending p detached for use as	M/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	200
m	death e atte ed for	icla	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 0	ctopic pregnancy Other (s <i>pecify</i>)		Month	Day Year
P. 0.	at the by th	hys	9 Unknown				
ś	w requires that been signed k should be det	by	Part II. Other significant conditions contributing to death but not resulting in the und		m	o use contribute to the	
ord	requii een s hould	sted	REMAL FAILURE CORDWARY ARTERY	DIJENE	1 🗆 Yes	2 No 3 Prob	pably 4 Unknown
Division of Vital Records,	e law has b	Completed	HUPERTENSION DIABETES MELLITUI A	ITHAL FIBRILLATION		prior to co	psy findings available mpletion of cause of
a	n: Th icate r, pag				performed		20 NO NIA
ž	tanding Physician: The leath. for: After this certificate hathe funeral director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient	26. Place of Death			
ō	g Phy er this eral d	-	27. Manner of Death 28a. Date of Injury 28b. Time of		e 5 ☐ Residence 8d. Describe how in		y)
0	ath. r: Aft	atlo	1X Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
<u>N</u>	r Atta er de racto by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office	Bf. Location (Street City or Town, Str	and Number or Rura	l Route Number,
	italo Irsaft ral Di lled in						
	Hosp 24 hou Funa Tely fii	edical	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation)	ccurred at the time, date and place, and stigation, in my opinion, death occurred	nd due to the cause of at the time, date a	(s) and manner as stand place, and due to	ated.
	To the Hospital or Attanding Physician: To the Funaral Briedor: To the Funaral Briedor: After this certifica completely filled in by the funeral director;	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		Date signed (Month,	
	+ ≥ F 8		Dr Filuje Heine - Manualdine	D0058542			
	10	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Pri				
	-		IN CORREIA AVENUE & SIS WIME	ATON MI) 2096	12	- 1 7 1 - 444	
	Sta	te	31. Date filed (Month, Day, Year) DEC 28 2004 32. Registrar's Signature	1			
	Registr	ar	UEU 60 4004 A	sparks			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** 31 2004 6:30 p.m. December RUTH MARIE /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Prince George's Adelphi Hillhaven Nursing Home If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) June 2, 1922 Birthplace (State or Foreign Country)
 Ohio If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex **Funeral** Days Hours 1□M 2ਊF Months 82 Director 287-12-0381 Usuel Residence of Decedent permit. Pages 1 end 2 should be filled within 72 hours efter death with the Marylend Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumetic event, the Medical Evandral must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Funeral Director Maryland Frederick Myersville 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 11129 Easterday Road 21773 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Detes: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be Joseph August Langenderfer Mary Philomena Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 12638 Millstream Drive, Bowie, MD 20715 Marguerite Dobrosielski/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 1-7-05 Frederick, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 504 Main Street Myersville, MD 21773 Ricketts Funeral Home 23a. Par 1. Ent r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she k, or rear failure. Set only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical ATMEROSCLEROTIC CARDIOVASCULAR DISTASE 15 YEARS Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No To the Hospital or Attending Physwithin 24 hours efter deeth.

To the Funeral Director: After this complately filled in by the funeral dir this 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as steled.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medicai 29a. Certifier (Check only one) 29b. Signeture en 29c. License number 29d. Date signed (Month, Day, Yeer) D31563 JANUARY 5 2005 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 1080(LOGIWOOD DR \$205 SILVER SARING MD 2090) MD CHAPLES IN BENNER 31. Date filed (Month, Day, Yeer) Registrar's Signature State **JAN 12** 2005 Registrar

			1 - For State Registrar	State of M	/larylan	d / Depa <i>Cei</i>	artmen rtificat	t of He	ealth a Death	and M	ental Hy	giene		-	42655
	Dharini		1. Decedent's Name (First, Middle	e, Last)							2. Date of De Month	eath Day	/ Ye	ar	3. Time of Death
	Physici /Medic		ANITA	ANN		FLOWER	RS				DEC.	28,	2004		0542 A M
	Examin		4a. Facility Name (If not institution	, give street and numbe	er)		4b. City,	Town, or	Location of	of Death		4c.	County of D	eath	
			Montgomery Ger	eral Hospit	tal			lney					Montg		
	Funeral		5. Social Security Number	6. Sex 7. A 1 □ M 2 □ F	-	last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)	9.	Birthpla Countr	ice (State or Foreign y)
	Director		408-54-9044	TOM ZX	7	0 Yrs.					FEB. 9	, 193			essee
	and *	}	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10	d. Inside City Limits
	sho	5		roll		Mount	Airy	J						1.0	1 ☐ Yes 2 € No
	he N	Director	10e. Street and Number									10.00			
	with (Di					10f. Zip						zen of Wha		
	s 23	Funerai		Road		0 140		21771		0 (0			ted		
	er de	une	11. Marital Status	12. Was Deceder Armed Forces	s?	.S. 13. \	Was Deced If Yes, spec	ient of His cify Cuban	spanic Ori n, Mexicar	igin? (Spe n, Puerto I	cify Yes or N Rican, etc.)	0~	14. Race - A Black, V		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates			1 🗆 Yes	2∏ No	Specify:				Specify:	Wh:	ite
5-0036	filed within 72 hours after death with the Maryland Hyglene. thar than "natural", or items 23a or 28a-f show that the Mscilical Examinar must be notified at	edit	15. Decedent			16a, Dece	dent's Heur	d Occupa	tion			16h Ki	nd of Busine		
5	in 72	jet	(Specify only highes	st grade completed)		(Give	kind of wo	rk done di	urina mos	it of worki	ng	100.10	ild of busine	333/11/00	istry
2121	with lene.	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	F	Iomema	ker				0	wn h	ome	
0	filled Hyg othar ant,		17. Father's Name (First, Middle,	Last)				-	18. Mothe	er's Name	(First, Middle			Onic	
lan	d be ental kad c	To Be	Roger	Ex	vans				M	yrt1e	2		Walton	n	
Maryland	2 should be filed withir and Mental Hygiene. is markad othar than aumatic avant, the M	-	19a. Informant's Name/Relations			19b. Mailir	ng Address	(Street a							Code)
S	ges 1 and 2 should be filed within 72 hc t of Health and Mental Hyglene. If item 27 is marked other then "natur or other traumatic avant, the Medical		Cindy Keefer /			5693	Ride	e Rd	. / M	ount	Airy,	Marv	land	217	771
ē,	permit. Pages 1 and Department of Health Important: If item 27 any injury or othar tr once.		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nan	ne of			ate		cation - City		
10	Pages nent of H ant: If ite ury or of		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		(8)	emetery, crer	-			12/20	12001	D1		M	1
Baltimore,	permit. Pag Department Important: I any injury c	li	21. Signature of Funeral Service		rai	klawn	. Name an								aryland
Ba	permit. Departn Imports any inju		Bock and	1921		/				BLa					P.A.
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, h			shock of heart failure. List Immediate Cause (Final	only one cause on each	line.										nterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)			ulmo	NATI	9 a	rren	T					
1	Examiner				as a conseq	,									
		-	Sequentially list conditions,	b. Due to (or a	is a consequence	neuce op. √5 N/V	ye h	Ame						2	years
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	E										.2	
	and al-train	хаг	that initiated events resulting in death) Last		as a consequence									- 4	gears
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687	phys the	dicai		d. 1000		990	0 10 0	10000							- 2
	death certifica attending ph d for use as ti	Physician/Me	IF FEMALE:	23c. If yes, outcom	ne of pregna	incv						,	23d. Date of	doliston	,
Вох	atten for u	Sian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	2 ☐Feta	Ideath 3	Ectopic pr Other (sp					- '	Month		y Day Year
O.	that the de ed by the detached	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown		04111	3 0 11101 (3)								
Ω.	that the ed by detac		Part II. Other significant condition	ns contributing to death	but not res	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did	tobacco u	se contribut	e to the	cause of death?
Vital Records,	uires that signed I	d by									1 🗀	Yes 2[□ No 3 7	Probal	bly 4 ∐Unknown
Ö	w requir been si should	Completed					_		_		24a. Was		74h War		ny findinga avallahla
3e	has has	шp									auto		prior death	to com	sy findings available pletion of cause of
al											1 ☐ Yes	2 No		res 2	□No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: > /				Othou	p-		(Check only				1.
of	ys dis	2	1 Yes 2 No 27. Manner of Death	28a. Date of In		ER/Outpatier 28b. Time of		/A	4 140		ne 5 Res 8d. Describe			Specify)	
n	ling I	on	1 Natural 5 Pendin	g (Month, D	Day Year)	Injury	M	8c. Injury Work	es 2 🔲		ou. Describe	now injur	y occurred		
Sic	Nttandi death. ctor: A y the fu	icat	2 Accident investig	not be	niunt - At he				65 2	-	of Location	Stroot an	d Number o	r Dural	Route Number,
Division	I or Attanding I after death. Diractor: After 3 in by the funer	Certification:	4 ☐ Homicide determ	ined 28e. Place of I building,	etc. (Specify	y)	eet, ractory	, onice		2	City or To			Muran	Houle (Valide),
	ospital hours a unaral I		On Cartina Manualinia	- Dhysician, To the box	at of my less	vuladas dasti		-4 14 - 41-0-4		d elece e		(-)			<u> </u>
	a Hospital 24 hours a a Funaral I etely filled	edicai	29a. Certifier Certifyin (Check only 2 Medical	g Physician: To the bes Examiner: On the basis and manner:	of examina	tion and/or in	vestigation.	at the time , in my opi	e, date an inion, dea	ith occurre	nd due to the d at the time,	date and	place, and	due to t	he cause(s)
	To tha Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Mec	29b. Signature and title of certifie		/		290	. License	number			29d. Dat	e signed (M	onth, D	ay, Year)
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	(2)		7	Activity	7			039	9190			Dece	mber	2.	8,2004
,			30. Name and address of person		•		,	D1 4	1, -	D /	0.1	2 ***	0000		
			J. Garrett,	- 67	trar's Signa	8101 P	.10		⊥ip l	Ur./	Olney	, MD	2083	32	
	Sta Registr		or. Date filed (Month DE) U 92	9 2004 32. Regis	Juai a digila	A. A.	March.	2							

		1 - For State Registrar	State of		nd / Dep		Health and I	Mental Hygi	_	. 1.2650
Physici	an	1. Decedent's Name (First, Middle,						2. Date of Death Month		3. Time of Death
/Medic	cal	Peter Andres Fell 4a. Facility Name (If not institution,		nhar)		th City Town	or Location of Death	December	25, 2002 4c. County of De	
Examin	ner .	Montgomery Hospi	•				ockville	ı	Montgo	
Funeral			S. Sex		. last birthday	If Under 1 Year	r If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
Director		219-35-4165 Usual Residence of Decedent	1 ⊠ M 2□ F	80	Yrs.	Months Days	Hours Min.	(Month, Day, August 3	, 1924 Ph	ilippines
show	or	10a. State 10b. County			ity, Town or L					10d. Inside City Limits 1 X Yes 2 No
28a-	rect	Maryland Montg	omery	R	lockvi1	.1e		10	g. Citizen of What	
32 or	Funeral Director	504 Longwood Dri	lve			208	350		United St	*
ems 2	ner	11. Marital Status	12. Was Dece		J.S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puert		14. Race - Ar	nerican Indian,
il Hygiene. othar than "natural", or items 23s or 28a-f show vant, it e Modical Examiner: ust be millied at	by Fu	1 ☐ Never Married 2 A Marrie 3 ☐ Widowed 4 ☐ Divorced		2 ∑ No e		1 ☐ Yes 2X No		o Alcan, etc.)	Specify: A	
"natural", dical Ex.	Completed by	15. Decedent's (Specify only highest	Education		16a. Dece	edent's Usual Occu	pation	1	6b. Kind of Busines	ss/Industry
ne.	nple	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use retire	/	King		
ital Hygiene. id othar than "natur avant, it e Modical		17. Father's Name (First, Middle, La	5+			Teache			Educati	on
ad of	Be	Dionisio Felipe	3 <i>51)</i>				Claudia	ne (First, Middle, M	aiden Surname)	
nd Me mark matic	은	19a. Informant's Name/Relationship	o (Type, Print)		19b_Maili	ing Address (Stree	t and Number or Ru		City or Town State	Zin Code)
alth ar 127 is ar trau		Hermelina Felipe					Drive; Ro			
of He fitan roth	28	20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3	□ Pomoval from S	20b.	Place of Disponent	osition (Name of omatory or other pla	ace) Decem	pate ber 27,	0c. Location - City	or Town, State
ment lant: jury o		`4 □Donation 5 □ Other (Spe	ocify)		thaver	Cremato			ederick,	Maryland
Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic ave once.		21. Signature of Funeral Service Li	cersee		Ŕ	2 Name and Addr estnaven 501 Catoo	Funeral Scrin Mcn.	Services, Hwv. Fre	Skkot Co	ody P.A.
nysician		23a. Part Enter the discovery shoot, or heart failur. Little Immediate Cause (Final disease or condition	plications that can't one cause on ea							Approximate Interval Between Onset and Death
Medical kaminer	er	resulting in death) Sequentially list conditions, if any, leading to immediate	b	or as a consec						
ohysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (d	or as a consec	quence of):					
physic s the b	dlcal		d							
attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 ☐ Feta ant at time of c	al death 3[□Ectopic pregnanc □ Other (specify) _	çy		23d. Date of d Month	elivery Day Year
signed by the s		Part II. Other significant condition:	s contributing to de	ath but not res	sulting in the u	ınderiving cause g	ven in Part I.	23e. Did toba	cco use contribute	to the cause of death?
been sign should be	ted by								_	Probably 4 Unknown
r this certificate has be iral director, page 2 sh	Completed							24a. Was an autopsy perform	prior to death?	
certif	Be o	25. Was case referred to medical examiner?	Hospital:					th (Check only one		
rr death. actor: After this by the funeral dii	tlon: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigal	28a. Date o		ER/Outpatier 28b. Time of Injury	of 28c, Inju Wo	ry at ork?] Yes 2 □ No	ome 5 Residen 28d. Describe how		ecify) Hospice
within 24 hours after death. To the Funaral Diractor: After completely filled in by the funer	Certification:	3 Suicide 6 Could no determine	ed 286. Place	of Injury - At h g, etc. (Specil	ome, farm, st fy)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or I State)	Rural Route Number,
Funar Funar ely fill	edical (29a. Certifier 1 ☑ Certifying (Check only one) 1 ☑ Medical Ex	Physicien: To the later on the base and manners	sis of examina	owledge, deat ation and/or in	h occurred at the ti	ime, date and place, opinion, death occur	and due to the cau	se(s) and manner a e and place, and du	as stated. ue to the cause(s)
within 2 To the complet	Me	29b. Signature and tille of certifier				29c. Licen	se number	290	d. Date signed (Mor	nth, Day, Year)
) \ \X\		W	7	D 35	5635	De	cember 25	, 2004
9)		30. Name and address of person wh				,	0 - 1 1 1	MD 2005	E	
Sta	to	Joseph Kaplan, N					KOCKVILLE,	, rw 2085	· · · · · · · · · · · · · · · · · · ·	
Registra	4	DEO 2 J	2004	To Sept Sent	fath for	foreste)				

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1 - State Registrar				Ce	rtificat	e of L	Death		Reg. 1	4004	426=	
ici	an		ne (First, Middle, La		•					2. Date o		22 2004	3. Time of D	
dic	cal ner			nawalt, Sr		-	4b. City.	Town, or	Location of Dea	Noven		22 2004 4c. County of De		
	lei		-	al Hospita				eric	k		-	Frederi	ck	
l r		5. Social Security N 261-45-4	4039	Sex 7. Ag 1 M 2 □ F	ge (In yrs. la 45	ast birthday) Yrs.	Months	1 Year Days	If Under 24 Hr. Hours Mir		Birth Day, Yea 10	9. B 1959 Nia	Birthplace (State or F Country) 1gra Falls	
	tor	10a. State MD	10b. County Washing	ton	1	, Town or Lo						,	10d. Inside City	
	Funeral Director	10e. Street and Nu 18850 Ar	rthur Lan	e	.1		10f. Zip	Code 1758			10g. (Citizen of What Country? USA		
	by	11. Marital Status 1 Never Marital Status	ried 2 Married	12. Was Decedent Armed Forces' 1 ☑Yes 2 ☐ If Yes, Give Year or Dates:	? No		Was Deced If Yes, spec	cify Cuba	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes o nto Rican, etc.	No-	o- 14. Race - American Indian, Black, White, etc. Specify: White		
	Completed	Elementary/Sec	15. Decedent's E cify only highest gr ondary (0-12)	Education rade completed) College (1-4or	5+)	(Give life.	DO NOT u	dent's Usual Occupation kind of work done during most of workin DO NOT use retired)			Ī	Kind of Busines Manufact	·	
	Be		(First, Middle, Las	,					18. Mother's Na	•	idle, Maid	en Sumame)	Luring	
	2		iame/Relationship			19b. Maili	ing Address	(Street 2				y or Town, State	, Zip Code)	
		20a. Method of Dis	•		fother P.O. Box 5, Everett, PA 15537 20b. Place of Disposition (Name of competent cramatons of other class) Date 20c.						Location - City	or Town, State		
			5 ☐ Other (Special)	□Removal from State ify)	9	-	-		ory 11/2	29/04	На	gerstown	n, MD	
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	Physici /Medic		1. Decedent's Name (I	NE				LASER		I	Date of Dea Month OCC.		20 0 4	3. Time of De 13:55	eath M
	Examin	er	4a Facility Name (If no Univ. Of	at institution, giv	e street and nui and Me	n <i>ber)</i> edical	Syst	4b. City, Town, o Baltir	more			4c.	County of De	ath	
	Funeral Director		5. Social Security Num 235–20–8590	0 1	ex □M 2☐xF	7. Age (In yrs 81	. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day Ine 26	(, Year)	9. B 23 Wes	nthplace (State or F Country) t Virgini	oreign La
	land bw	}	Usual Residence of De 10a. State 1	ob. County		10c. C	ity, Town or Lo	cation						10d. Inside City	Limits
	Mary a-f sh	tor	Maryland	Frederi	ick	F	rederio	:k						1x Yes 2	□ No
	with the	i Direc	10e. Street and Number 708 Wyngat		2			10f. Zip Code 217	01				izen of What C	Country?	
	death	nera	11. Marital Status		12. Was Dece	edent Ever in	U.S. 13.	Was Decedent of H f Yes, specify Cub	Hispanic Or	rigin? (Specify	Yes or No-		14. Race - Am Black, Wh		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other than "netural; or itams 23e or 28e-f show say injury or other treumatic event. The Madical Exacilitat must be multical and once.	Completed by Funeral Director	1 Never Married 3 Widowed 4 [_	1 □ Yes If Yes, Giv Year or D	2 X No		1 ☐ Yes 2 ☑ No			ari, 6(0.)		Specify:	white	
21215-0036	hin 72 ho s. sn *netu l M. Jic. II	pieted	(Specify Elementary/Seconda	5. Decedent's Education only highest graduate (0-12)	ducation ade completed) College (I-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	oation during mod d)	st of working		16b. K	ind of Busines	s/Industry	
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Baltimore,	permit. Pages 1 and 2 Department of Health a important: if tem 27 is sny injury or other tre		1 XXurial 2 □ 0	Cremation 3		State	cemetery, crer	matory or other plan		12 –18– 2			•		ال.
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Vital		To Be	examiner?)	Hospital: 1 X	Inpatient 2[☐ ER/Outpatier	it 3 DOA Oth	205	e of Death (C			6 □Other (Sp	acifu)	_
n of			27. Manner of Death	5 Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Injur Wor	ry at rk?	28d	. Describe h			ony)	
Division	ten leat tor: the	Certification;	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not be determined	e 28e. Place	of Injury - At ng, etc. (Spec	home, farm, str	M 1 []	Yes 2.⊡	-	Location (Si City or Town	treet an n, State	d Number or F)	Tural Route Number	r,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Medical Ce	(Check only 2[Certifying Ph Medical Exar	niner: On the b	asis of examir	nowledge, death	n occurred at the time time time time.	me, date a	nd place, and ath occurred a	due to the c	ause(s) late and	and manner a I place, and du	s stated. e to the cause(s)	
	o the ithin 2 o the orplet	Med	one) 29b. Signature and titl	e of certifier	and man	ner stated.		29c. Licens	se number		2	9d. Dat	e signed (Mon	th, Day, Year)	
	F ≱ F 8		1		net			P194					c. 27,		
(10		30 Name and address	s of person who arles,	completed cause MD 22	se of death (Ite	em 23a) (Type, Ceene	Print) St. Bal	timo	re, Mo	d 212	01			
	Sta	te	31. Date filed (Month)			egistrar's Sigr		radi)							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 42659 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MARGARET F. GERWIG 4:50 A M December 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Home Boonsboro tahrney Keedy Nursing Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth Month, Day, Year 5/27/1919 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 TF TENNESSEE 234-80-6659 85 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MARTINSBURG 10d. Inside City Limits If Item 27 is marked other than "natural", or Items 23a or 28a-f sho or other treumatic event, Ite Modical Examinar must be notified at 3244 EAGLE SCHOOL ROAD APT. 4 Director BERKELEY 1 Yes 2/No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3244 EAGLE SCHOOL ROAD APT. 25401 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Specify: WHITE If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be it of Health and Mental WILLIAM S. LEDBETTER NANNIE THURMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY GERWIG/DAUGHTER 1801 COBOURG CT. APT. T-2, BALTIMORE, MD 21234 20b. Place of Disposition (Name of 20a. Method of Disposition JANUARY 20c. Location - City or Town, State BUSH CREEK BRETHREN CHURCH CEMETERY 1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Importent: if any injury or once. MONROVIA, MD 3**,** 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility BROWN FUNERAL HOME 327 W. KING ST., P.O. BOX 821, MARTINSBURG, WV 25402 haeles m 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascalar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physicien for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ funeral director, page 2 should be Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 Yes 2 No Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2√No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 TYes 2 TNo 2 Accident investigation the 24 hours after deatl Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitel or dt. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within a 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12/30/1 NC5353 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WASEEM KHALID M. 1126 OPAL COURT, HAGERSTOWN, MD 21740 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Nargaret F. Gerwig

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

		1 - For Amend Item 10 Registrar		inform	ant G841 fullicate of L	3-22-05 t			42660
Physic		Decedent's Name (First, Middle, Last LOREN M	orton Goodi	MAN			2. Date of Death Month DFCFMRF	Day Year X 24, 2004	3. Time of Death 5:45 A M
/Medi Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	DICHIDE	4c. County of Dea	
v v	1	SUBURBAN HOSPITAL			It Hadas 1 Vans	BETHESDA		MONTGON	
Funeral Director		5. Social Security Number 6. S 220–12–3881	9X 7. Age (In yrs. 79	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, JUNE 23	9. Bir Co 1925 WAS	thplace (State or Foreign ountry) SHINGTON, DO
and		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation			/	10d. Inside City Limits
5-0036 72 hours after death with the Maryland natural', or Items 23a or 28a-1 show are I Examiner must be notified at	to	Florida Broward MARYLAND MONTGOM			o Reach				1 Yes 2 No
vith the	Director	10e. Street and Number 808 Cypress Blvd. 5000 NICHOLSON LA	. #408		10f. Zip Code 33 0	169	10	g. Citizen of What Co	ountry?
Jeath v	Funeral	11. Marital Status	12. Was Decedent Ever in U	I.S. 13.	Was Decedent of Hi	spanic Origin? (Spe		14. Race - Ame	
after or Ite	Fur	1 Never Married 2 Married	Armed Forces? 1 Tyyes 2 ☐ No If Yes, Give		if Yes, specify Cubai 1 ☐ Yes 2 X No	n, Mexican, Puerto I Specify:	Rican, etc.)	Black, Whit	
tural;	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Eq.	Year or Dates: WWI]	L	dent's Usual Occupa	•	11	Specify: W	HITE
21215-0036 ed within 72 hours aff giene "natural", or er the Modical Excent	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of work done d DO NOT use retired,	luring most of workir	ng "	ob. Kind of business	industry
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2 shou and M	-	19a. Informant's Name/Relationship (1	ype, Print)	19b. Mailir	ng Address (Street a			City or Town, State, 2	
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ages 1		20a. Method of Disposition 1 X Burial 2 Cremation 3 X	Removal from State	cemetery, crer	sition (Name of natory or other place	9)		Oc. Location - City or	
Destinations Sermit, Pages 1 at Deportment of Heal mp. cream: If item into niury or other pages.		' 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen						CHAPELS,	CH, VIRGINI
		1 rungt	h/ Jun.	111	70 ROCKVI	LLE PIKE,	ROCKVII	LE, MD 2	0852
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Examiner		Company of the same of the sam	CONGESTIV		T FAILURE				YEARS
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hat the death certified by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d	Il death 3	Ectopic pregnancy Other (specify)			23d. Date of del	very Day Year
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vital necolus, sicien: The law requires t certificate has been signe rector, page 2 should be c	omo						autopsy performe	prior to death?	topsy findings available completion of cause of
	Be C	25. Was case referred to medical examiner?				26. Place of Death		▼No 1 □ Yes	2 L No
	P	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatien		4 Nursing Horr		ce 6 □Other (Spec	city)
Attending Phragon death. Sector: After this by the funeral	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time of Injury	28c. Injury Work' M 1 □ Y	at ? 'es 2 □ No	8d. Describe how	injury occurred	
	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pface of Injury - Al ho building, etc. (Specif	ome, farm, stre	eet, factory, office	2	8f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
To the Hospitel or Al within 24 hours after or To the Funerel Directompletely filled in by		29a. Certifier Certifying Phy	lir						
te Hospite 124 hours te Funerel	edical	(Check only one)	vsician: To the best of my know iner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my opi	e, date and place, a inion, death occurre	nd due to the cau d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of pertifier	1.		29c. License	number	290	. Date signed (Month	, Day, Year)
Ś		July 11	MA		D36	046	D	ECEMBER 2	4, 2004
			completed cause of death (Iten D, M.D., 10215		,	SUITE #4	05 ВЕТН	ESDA, MD	20817
Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signa	-	hooded			,	
Regist	ar	DEC 28 200	4	The same of	1				

State of Maryland / Department of Health and Mental Hygiene $2 \bigcap \bigcup l_{\sharp}$ 42661 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DECEMBER 27, 2004 **GUBERMAN** MURIEL 1:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CASEY HOUSE - MONTGOMERY HOSPICE MONTGOMERY ROCKVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year MARCH 10, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1 ☐ M 2 🗓 F 1915 NEW YORK Director 124-28-2873 89 Usual Residence of Decedent with the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any july or other traumatic event, the Medical Even it are must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 ☐ No MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3701 INTERNATIONAL DRIVE, #748 20906 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No ð Specify: Specify 3 ♥ Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) SECRETARY SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BLUMBERG DAVID ROSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN GUBERMAN, DAUGHTER 14805 PENNFIELD CIRCLE, SILVER SPRING, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donayio 5 ☐ Other (Specify SOUTHWEST RANCHES, FL MENORAH GARDENS 12/30/2004 21. Signature of Funcial Service Licensee DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 10 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and shed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 🗓 No certificate Division of Vital 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other ${}_{4}$ Nursing Home ${}_{5}$ Residence ${}_{6}$ Mother (Specify) HOSPICE ۴ 1 ☐ Yes 2√ No 3□ DOA After thi funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 5 Pending investigation death. I Director: / 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check or one) 29b. Signat re and title 29d. Date signed (Month, Day, Year) 29c. License number D35635 DECEMBER 27, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH KAPLAN, M.D., 9715 MEDICAL CENTER DR., #221 ROCKVILLE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 28 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav Month Year URSULA EDITH GEOGHEGAN 12 /Medical 28 04 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Worcester Berlin Atlantic General Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 9. Birthplece (State or Foreign 1 M XX Days Hours 62 Director 215-40-6048 Germany 8/4/1942 Usual Residence of Decedent 10a. State 10b. County ral', or Itams 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Ocean Pines Yes 2 □ No MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ent: If item 27 is marked other then "natural", or Itams 23e or ury or other freumatic svent, tra Medical Exam as must must be a 15 Candytuft Lane 21811 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Clerk Utility Co. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 Sam A. Rasken Anita Ruppelt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph P. Geoghegan 15 Candytuft Lane Ocean Pines, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12/28/04 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Importent; If any injury or Cape Henlopen Crematory 4 □ Donation 5 □ Other (Specify) Frankford, DE 22. Name and Address of Facility he Burbage Funeral Home 21. Signature of Funeral Service Licensee Ta. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hean-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician broncho disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, the attending physician detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1 Yes 2 - No uneral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Certification: To 1 Yes 2 No 1 Inpatient Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury death. ours after death.

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filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel within 24 hours a To the Funerel (29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) Oly SICII 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6.1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 9 ENEWER Registrar

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			1 - State Registrar			rtificate of			g. No. 2001	1 42663
	Physic	20	1. Decedent's Name (First, Middle, La.	st)				2. Date of Deat Month		3. Time of Death
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Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if Item 27 Is any injury or othar tra		1 ☐ Burial 2 1 Cremation 3 ☐		cemetery, cren	natory or other pla		mber 29,	Oc. Location - City or	
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	the H in 24 tha Fi	Medical	(Check only 2 Medical Examone)	iner: On the basis of e and manner state	xamination and/or inv	estigation, in my o	pinion, death occu	rred at the time, date	e and place, and due	to the cause(s)
	To To	2	29b. Signature and title of certifier	0		29c. License		290	d. Date signed (Month	Dey, Year)
	X		1001111	Y		000	51924	D.	ecenber 2°	5, 2004
	V		30. Name and address of person who c	ompleted cause of dea	1th (Item 23a) (Type, F	Print)	D 1 1	1	er mo	7.47
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Registrar

DEC 28 2004

1- State Registrar Physician Medical Examiner 1. Decedent's Name (First, Middle, Last) Reg. No. 1. Decedent's Name (First, Middle, Last) Reg. No. 2. Date of Death Month Day Year 1:000 Anoth Dec 28 2004 4a. Facility Name (If not institution, give street and number) 4a. Facility Name (If not institution, give street and number) Anoth Dec 28 2004 4b. City, Town, or Location of Death Anoth Death Ac. County of Death Ac. County of Death Anoth Death Ac. County of Death Anoth Death Ac. County of Death Anoth Death Ac. County of Death Anoth Death Ac. County of Death Anoth Death Ac. County of Death Ac. County of Death Anoth Death Ac. County of Death Anoth Death Ac. County of Death Anoth Death Ac. County of Death Ac. County of Death Anoth Death Ac. County of Death Anoth Death Ac. County of Death	Death
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The state of the last of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
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Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a	
D36494 12-28-04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
* DESAIMS University specifity hospital Gol south charles st Ballimore MD & 1236	
State 31. Date filed (Month, Day, Year) Registrar 32. Registrar's Signature	

Replacement Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Unpend Item 23a&27 per me G830 erilitale of Beath . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2, Eric Alan Ivins December 12:18 P M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 783 Belair Ave. Aberdeen Harford 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Director 219-72-9261 32 11-01-72 Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 ☐ No Director MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23s or U.S.A. 26 Graceford Drive 21001 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 🔀 Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>À</u> Specify: White 3 Widowed 4 Divorced Year or Dates: 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Web design Computers other treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi and Mental H is marked of permit. Pages 1 and 2 should be Department of Health and Mental Importent: if item 27 is marked c any injury or other treumetic ever 2008. Franklin Thomas Ivins Jacquelyn Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 Graceford Dr., Aberdeen, Maryland 21001 Franklin T. Ivins (Father) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12-7-04 Aberdeen, Maryland St.Paul's Lutheran Cem. 22. Name and Address of Facility
Tarring-Cargo Funeral Home,. P.A. 21. Signature of Funeral Service Licensee Tara Zellman per dvr Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician Heart Failure Due To Cardiomegaly disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certiticate be executed physician and is the burial-trans Due to (or as a consequence of) Box 68760 Physician/Medicai IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 Other (specify) Division of Vital Records, P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes Yes 2 🗌 No 1X Yes 2□No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 v ther (Specify) Scene To 1 ¥Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funerel Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No

Registrar DHMH 17 Rev 1/2001

Medical

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

111 Fenn Street Baltimore, Maryland 21201

28f. Location (Street and Number or Rural Route Number, City or Town, State)

anuary

14, 2005

investigation

Name and address of person who completed cause of death (Item 23a) (Type, Print)

8

MD

20032. Registria Signature

6 Could not be determined

3 Suicide

Pamela

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certified

			1. For Statemend item 11:	State of	Marvlan	d / Depa	artment of rtificate o	Health a	and M	ental Hygi	ene g. No.20	04	42667
	Physici /Medic	al	1. Decedent's Name (First, Middle,	TTOGOTT	ner)		4b. City, Town	or Location	of Death	2. Date of Death Month 1 2	Day Z 6	Year 2004	3. Time of Death 5.48 PM
	Examin	er	4a. Fecility Name (If not institution,	ASV ENT		PML	TAX.	-	PARIO			100	MERY
	Funeral Director		5. Social Security Number 212-98-3573			last birthday) Yrs.	If Under 1 Yea Months Day		Min.	8. Date of Birth (Month, Day, JUNE 8,	1949	9. Birthpla Count GUYA	ace (State or Foreign ry) NA
land	ous affer death with the Maryland et, or Items 23a or 28a-1 ehow Examiner matel by notified at		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10	d. Inside City Limits
э Магу		ctor	MD. MONTGO	MERY			SILVE	R SPRII	NG				1 XYes 2 ☐ No
with th	Nor 28 De no	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of		ry?
leath v	ns 23g	Funeral	9203 NEW E	12. Was Deced	-	.S. 13. 1	Was Decedent of If Yes, specify Co	20903 of Hispanic Ori	-	city Yes or No-		S.A. ce - America	n Indian,
Te.	el, or itar Examinar	by	1 Never Married 2 Married 2 Married 2 Divorced	Armed Force 1 Tyes 2 If Yes, Give Year or Date	™ 0		If Yes, specify Ci			Rican, etc.)	Specif	ck, White, e	tc.
5-0 72 hg	"naturel", dical Eva	eted	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece (Give	dent's Usual Occ kind of work dor	cupation ne during mos	at of workir	ng 1	6b. Kind of B	usiness/Indi	ustry
21215-0036 d within 72 hours af	then then	Completed	Elementary/Secondary (0-12)	College (1-4	lor 5+)	ilre.	DO NOT use reti				ноя	SPITAL	•
פַ פַּ	ental Hygiene. ked other then "natu ic event, ihe Medical	0	17. Father's Name (First, Middle, L	ast)	ONG			-	(First, Middle, M		ne)	,	
ary shou	and Menta • marked • umatic • v	F	19a. Informant's Name/Relationship		<u> </u>	19b. Mailir	ng Address (Stre	et and Numbe		Route Number,			Code)
and 2	m 27 i			/NIECE	205 0		KNOWLES			SINGTON,			- Ctato
nore	Contract of the state of the st		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		ate	emetery, crer	matory or other p	olace)			Oc. Location		
Baltimore, permit. Peges 1 a	Department of Health and Menta Important: If Item 27 ie marked eny injury or other treumatic evonce.		* 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L		<u>С</u> моо	22 C		FUNERA	AL HO	-2004 ME & CRE , RIVERD		CUM,P.	Α.
760, te be executed U / H	sician Medical Kaminer Kaminer	Ical Examiner	23a. Part1. Enter the disease, or o shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Anter Due to (or Due to (or C.		uence of):	er the mode of d	tying, such as	cardiac or	r respiratory arres	st,		Approximate Interval Between Onset and Death
Hecords, P.O. Box 68 The law requires that the death certifica	by the attending phy tached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ₩0 9 □ Unknown		h 2∏Feta nt at time of d	Ideath 3	Ectopic pregnar Other (specify)					te of deliver onth E	y Day Year
dS, P.	been signed by should be deta	þ	Part II. Other significant condition	s contributing to dea	th but not res	ulting in the u	nderlying cause	given in Part I	,	1	cco use cont	ribute to the	cause of death?
Hecords, The law requires t	has Je 2	Completed								24a. Was an autopsy performs	ed?	Were autop: prior to com death? 1 \(\sum Yes \) 2	sy findings available pletion of cause of
Vital	certificate rector, pag	Be	25. Was case referred to medical examiner?	Haspitali		/	= 1,		of Death	(Check only one) –		-
Phys	this al di	7.	1 Yes 2 No	Hospital: 1 Ing		ER/Outpatier 28b. Time of	" 3 DOX			ne 5 Residen			
ION Inding	ath. r: After e funer	ation	1 atural 5 Pending 2 Accident Investiga		Day Year)	Injury	f 28c. In W	Vork? □Yes 2□	No				
2 5	s after death. al Director: A ad in by the fu	Certification;	3 Suicide 6 Could no determine	280. Place o	f Injury - At ho , etc. (Specif	ome, farm, str	eet, factory, offic	≎e	2	8f. Location (Stre City or Town,		er or Rural	Route Number,
he Hospit	within 24 hours affe To the Funerel Dir completely filled in	Medical (29a. Certifier 1 Certifying (Check only one)	Physician: To the b xaminer: On the bas and manne	is of examina	wledge, death tion and/or in	n occurred at the vestigation, in m	time, date an y opinion, dea	nd place, a ith occurre	ed at the time, dat	e and place,	and due to t	he cause(s)
To tl	To t	Σ	29b. Signature and title of certifier					ense number		296	d. Date signe		
(5)v		Janua dudon		of death (line	- 02a) (T	1	5427			11-2	6-200	7
•			30. Name and address of person w	A	of death (Iten	n 23a) (Type,	Print) MD	24	my	Ux	BAM	Mi	•
	Sta	te	31. Date filed (Month, Day, Year)	32. Rec	gistrar's Signa	iture 4	home	11			•	*	
-36	Registi	ar	DEC 28	2004	per	1	jugiona						

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 24, 2004 **Physician** Jacob M. Kleiman 10:15A. M /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country)
 New York 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 10 M 2 □ F 132-01-8393 89 Yrs July16,1915 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Items 23s or 28s-f show jiene. ir than "naturel", or Itema 23e or 28a-f shov tra Medical Examinar must be notified at 1 Yes 2 □ No Maryland Prince George's Hyattsville by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4008 Underwood Street 20782 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Itema 23a any injury or other treumatic event. If a Medical Example reserved. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ∑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
(Jithe DO NOT use retired)
Administrator of Health 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Federal Government and Human Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Morris Kleiman Sarah Diller 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Kleiman -son 11709 Chilcoate Lane Beltsville, Maryland 20705 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Metropolitan Crematory 12/26/2004 Alexandria, Virginia 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 ald b 23a, Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or espiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list curvatures, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cor Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequ Box 68760. the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Year in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, page 2 should be 1 Yes 2X No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 XNo certificate 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral I completely filled Medical 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nasreen Kango, M.D. 7610 Carroll Avenue Takoma Park, Maryland 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **DEC 28** 2004 Registrar

			For State Registrar	State of M	arylan	•		nt of H te of L		ind M		jiene	nnı	1,2671
Ì	Physici /Medic		1. Decedent's Name (First, Middle, Las ALICE E. KNOX								2. Date of Dea Month Decemb	Day	Year 2004	1
	Examir	er	4a. Facility Name (If not institution, give Penning Value) 5. Social Security Number 6. S	1 Medica	1 0	N/W last birthday)		JALI er 1 Year	Location o	1	8. Date of Birth		-	n/Co place (State or Foreign
	Funeral Director			THE STOR	83	Yrs.	Months	Days	Hours	Min.	(Month Day 02/10/	21 21 21	VA	ntry)
	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or tlems 23e or 28e-f show artic event, the Medical Evantinar must be rediffed at	ctor	VA Accoma	ack		y, Town or Lo Hornto								10d. Inside City Limits 1 ∑Yes 2 □ No
	or 28	Director	10e. Street and Number					ip Code				10g. Citizen o		ntry?
	eath v	eral	34240 Horntown	Rd.	Ever in II	S 13 1		23395	enanic Orio	in? (Sne	cify Yes or No-	US 14 B	SA ace - Ameri	can Indian
980	urs after de al', or Item	by Funeral	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:			f Yes, sp	2 2 No	Specify:	Puerto F	Rican, etc.)		lack, White,	etc.
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygene. Is marked other than "naturat", or items 23e or 28a-f show eumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		5+)	16a. Dece (Give life.	kind of w		furing most	of workin	ng .	16b. Kind of	Business/Ir	ndustry
2	lled wi tygien her th		17. Father's Name (First, Middle, Last)			La	oore	<u>r</u>	19 Mother	r's Nama	(First, Middle,		estic	
ylanc	should be find Mental Hammarked of	To Be	Sewell Handy						Vi	ctor	ia Town	send H	landy	
ă M	d 2 sh th and 7 is m treum		19a. Informant's Name/Relationship (, ,	r		-				Wn, VA		vn, State, Zij	o Code)
	ges 1 and 2 should it of Health and Mer If item 27 is marke or other treumatic		20a. Method of Disposition	·	20b. F	Place of Dispo cemetery, crei	sition (N	ame of	- 1			20c. Location	n - City or T	own, State
altimore,	Page nent o nnt: If		1 ♣ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Sepecify			bernac.				12/1	8/04	Horr	ntown,	VA
Balti	permit. Pages 1 and 2 Department of Health a Importent: If item 27 li any Injury or other tre 2008.		21. Signature of Funeral Several Lice	1 Chan	1	Co	oope	c & H	s of Facility	s Fu	neral C	o., Ac	comac	, VA
	Pnysician /Medical		23a Fart1. Enter the disease or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	/ /	cos	15	er the mo	ode of dying	g, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death S day S
8760,	The law requires that the death certificate be executed the lass been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a cons	wence of):	ct	In	fect	ion				
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	Ideath 3	Ectopic Other (pregnancy specify)				i i	Date of delive	ery Day Year
rds, P.	quires that in signed t uld be deta	by	Part II. Other significant conditions of	ontributing to death t	out not res	ulting in the u	nderlying	cause give	on in Part I.		23e. Did to	_/	_	he cause of death? pably 4 Unknown
I Records,		Completed	moxic encey	chalopath	y_						24a. Was a autops perform	in 24t sy med? 2DNo	o. Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available impletion of cause of 2 \(\text{No} \)
Vital	vysician: The sis certificate director, pag	Be	25. Was case referred to medical examiner?	Hannital:				104		of Death	(Check only or	(8)		
	this al dir	lon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: Inpatie 28a. Date of Inju (Month, Da	ıry	ER/Outpatier 28b. Time of Injury		28c. Injury Work	4 🗆 1401	2	ne 5 Reside 8d. Describe ho			(y)
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined		jury - At ho tc. (Specif	ome, farm, str					8f. Location (Si City or Town		mber or Rura	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dic completely filled in	Medical (ysician: To the best niner: On the basis of and manner st	f examina									
	To the To the comp	Ž	29b. Signature and title of certifier	//			2	9c. License	number		2	9d. Date sign	ned (Month,	Day, Year)
			Hurlelf					D-	3085	3	\(\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	12/	20/2	7
Ŀ	1.6		30. Name and address of person who	Ivia, Ju	m	0		100 E.	CHRRICO 1	en S	wal r	Ned 14	ma (e	nter
	Sta Regist		31. Date filed (Month, Day, Year)	004 32. Registr	rar's Signa	ature	route	B						

DHMH 17 Rev 1/2001

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		State of Maryla	and / Department of l Certificate of		Hygiene 004 42671
		Decedent's Name (First, Middle, Last)	2. Date of Month	Death 3. Time of Death	
and a	Physician /Medical	Felice McNee	cc	Decan	14/22 2004 8. /CA.
	Examiner	4a Facility Name (If not institution, give street end number)		4b. City, Town, or Location of Di	eath 4c. County of Deeth
		Ellicott City Health & Rehab (Center	Ellicott City	Howard
	Funeral	5. Social Security Number 6. Sex 7. Age (In y	vrs. last birthday) If Under 1 Year	Hours Min. (Month,	Birth Day, Year) 9. Birthplace (Stete or Foreign Country)
· ·	Director	5/8-12-8492	93 Yrs. Months Days	Mar.	28, 1911 Washington, DC
	pue }	Usuel Residence of Decedent 10a. State 10b. County 10c.	City, Town or Location		10d. Inside City Limits
	dary or	V 1 1 1 1	0 1 1 1		1 ☐ Yes 2 ☑ No
	the rect	Maryland Howard (Columbia 10f. Zip Code		10g. Citizen of What Country?
	ifer death with the Ma r frems 23s or 28s-fs ciner must be notilise Funeral Director	7070 Cradlerock Way Apt.#208	210	1/4.5	U.S.A.
	me 2	11. Marital Status 12. Was Decedent Ever in	n U.S. 13. Was Decedent of	Hispanic Origin? (Specify Yes or	No- 14. Race - American Indian,
0	72 hours effer death with the Maryland naturel; or items 23e or 28e-f show dicel Examiner must be notified at effect by Furneral Director			ban, Mexican, Puerto Rican, etc.)	
21215-0020	Per, o	3 ★ Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 反 No	Specify:	Specify: White
5-0	72 h	15. Decedent's Education (Specify only highest grede completed)	16a. Decedent's Usual Occu (Give kind of work done	pation during most of working	16b. Kind of Business/Industry
2	within ene.	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retire	9d)	
N	C Training	9th 17. Father's Name (First, Middle, Last)	Computers	18. Mother's Name (First, Mid-	U.S. Government
anc	should be filed within 72 hos and Mental Hygene. I marked other than "neture umatic event, the Medical I To Be Completed	77. Father's Name (First, Middle, Last)			
2	should and Men i marke umartic		10h Mailing Addrson (Ctros	Catherine Mura	MDITO mber, City or Town, State, Zip Code)
Maryland	end 2 si ealth end n 27 is n er traur	19a. informant's Name/Relationship (Type, Print) John McNeece / Son			a, Maryland 21045
Ġ,	Heal Heal orn 2	·	b. Place of Disposition (Neme of cemetery, cremetory or other place)	<u> </u>	20c. Location - City or Town, State
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours effer death with the Marylan Department of Health and Mertall Hybjane. Department of Health and Mertall Hybjane. Important: If them 27 is marked other than "naturel, or items 23a or 28a-f show any Injury or other traumatic event, the Marilest Examiner must be notified at once. To Be Completed by Funeral Director	1 Liburial 2 Lacremation 3 Linemoval from State			94Brentwood, Maryland
₫	artme ortan Injur	21. Signature of Funeral Service Licensea			NALDI FUNERAL HOME, INC.
ä	permit. Departr Importu any Inji	I along Daniel			Silver Spring, MD 20904
		23a. Part1. Enter the disease or complications that caused the dishock, or heart failure. List only one cause on each line.		-	
	Physician	shock, or heart failure. List only one cause on each line.		A	Interval Between Onset and Death
	/Medical	Immediate Cause (Final disease or condition	mine alivi	v Abrillave	
4	Examiner	resulting in death) a. Due to	o (or as a consequence of):		onset and Death
	physician and sthe buriel-transit	- Alm	ostlenta (andwarde	a Discal
	and trans	Sequentially list conditions,	o (or as e consequence of):		
80,	cian cian buriel	Sequentially list conditions, if any, leading to immediate ceuse. Enter Undertying Cause (Disease or injury			
68760,	icete be executed physician and sthe buriel-transit sthe buriel-transit edical Examil	that initiated events resulting in death) Last	o (or as a consequence of):		
×					1
Вох	The law requires that the death certif site has been signed by the eltending page 2 should be deteched for use e.	Control Colored Colore	late a least and all the second	in a la Bank I	Nid Ash and a shada a
<u>о</u> .	the cy the schex	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause g		id tobacco use contribute to the cause of death? Yes 2 No 3 Probably
ري ت	es that igned t be det by P			·	
Records,	quire			24a. W	/as an autopsy additional available prior to
ပ္က	s bed so show the piet				completion of cause of death?
č	The law requir			11	☐ Yes 2 No 1 ☐ Yes 2 L
ita	clan: ertifice ector, Be (25. Was cese referred to medical examiner?		26. Place of Death (Check on	ly one)
<u> </u>	Physician: rthis certific arel director,	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2	ER/Outpatient 3LI DOA		esidence 6 Other (Specify)
Ē	on:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year)			be how injury occurred
Sign	Attending r deeth. ector: After by the fune ifficatior	2 Accident investigation 3 Suicide 6 Could not be		Yes 2 No	n (Street and Number or Rural Route Number,
Division of Vital	tal or Attending P rs efter deeth. el Director: After t led in by the funere Certification:	4 Homicide determined building, etc. (Spe	at home, farm, street, factory, office ecity)		Town, State)
_	To the Hospital or Attending Physician: The law within 24 hours effect death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier 1 Certifying Physician: To the best of my	knowledge, death occurred at the t	ime, date end place, and due to t	he cause(s) and manner es stated.
	in 24 hour he Funer pletely fill edical	(Check only 2 Medical Examiner: On the basis of exam and menner stated.	ination end/or investigation, in my	opinion, death occurred at the time	ne, date and place, and due to the cause(s)
	Withir To the Comp	29b. Signature and title of certifier		se number	29d. Date signed (Month, Day, Year)
		1600	1)	30641	Decerter 22 2004
	3	30. Name and address of person who completed cause of death (I	tem 23a) (Type, Print)	n //	Rolling Halid
		Kanyn sampeller 34	00 Excemen	- merre	Decede 22 2004 Salhrere Hayland
	State Registrar	31. Date filed (Month, Dey, Year) 32. Registrar's Signer (Month) 28 2004	mature & spack	2	1 4107

			For State Registrar	State of Ma	aryland		artment <i>tificate</i>			and Me	ental Hy	giene Reg. No	/ 11	04	426	72
	Dhariai	9	1. Decedent's Name (First, Middle, Last)							'	2. Date of De	Da	ıy	Yeer	3. Time of	
	Physici /Medic		Georgianna Frazi	er Matth	ews						ecembe	er 2	2, 2	004	6:13	РМ
	Examin	er	4a. Fecility Name (If not institution, give s						Location o					of Deeth	_	
		*	1609 Wilson Place 5. Social Security Number 6. Sex		e (In yrs. las	st birthday)	If Under		Sprin	24 Hrs.	B. Date of Bir	th	Ť	omery 9. Birtho		r Foreian
48	Funeral Director			м 2 X Д F	101	Yrs.	Months	Days	Hours	Min.	(Month, Da	y Year	903	Coun	lace (Steta o try) unk	•
- 44	7		Usual Residence of Decedent		10 0:											
	arylar ehow	_	10a. State 10b. County			Town or Lo								1	0d. Inside Cit 1 X Yes	•
	filed within 72 hours after death with the Maryland Hygiene. other than "netural", or Iteme 23a or 28a-f ehow ent, the Medical Examinat must be notified at	Director	NC Guilford		Gree	ensboı	10f. Zip	Codo				10a Ci	tizen of \	What Coun		
	with the second		101 / Program Azzamus				101. Zip	Code						State	•	
	me 23	Funeral	1014 Broad Avenue	12. Was Decedent		. 13. \	Was Deced	ent of His	spanic Orig	gin? (Spec	rty Yes or No		14. Rac	e - Americ	an Indian,	
SO.	or Her		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ X	No		f Yes, spec			, Puerto R	ican, etc.)	1		k, White,		
ğ	ral', c	d by	3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	LANO	Specify:				Afri	can A	merica	an
2	72 h	Completed	15. Decedent's Educ (Specify only highest grade			16a. Deced	lent's Usua kind of wor DO NOT us	k done di	uring most	t of working	9	16b. H	(ind of Bu	usiness/Ind	lustry	
121	within sne.	dmi	Elementary/Secondary (0-12)	College (1-4or 5	5+)		ool Te					Ed	ucat	ion		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or iteme 23a or 28a'd show aumatic event, In a Madical Examinar must be notified at		17. Father's Name (First, Middle, Last)	<u> </u>	l					r's Name ((First, Middle	_				
an	m = 0 5	To Be	Charles Frazier,	Sr.					Sa11	ie Wo	oods					
ary	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Ie marked any injury or other traumatic evonce.	1 2	19a. Informant's Name/Relationship (Type	oe, Print)		19b. Mailin	g Address	(Street a	nd Numbe	or or Rural	Route Numb	er, City	or Town,	State, Zip	Code)	(
Σ	and 2 saith a n 27 le		Claude Matthews /	Son					N.E.	briefsterken.	shingt	-		200		
Baltimore,	of He of He if item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	сеп	ce of Dispo netery, cren	natory or ot	her place		Da				City or To		
Ě	Pages ment of I		* 4 ☐ Donation 5 ☐ Other (Specify)		Gui	lford			100	2/30/		776.		ro, l		
ga T	permit. Departr Importa any inje		21. Signature of Funeral Service License	90							ire F					
	20240		23a. Part 1. Enter the disease, or compli	my for	d the death						V.W.,		• В•	G. A	20012 Approximate	
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each li	ne.	DO NOT BITC	or trie mode	o dy mg	, such as t	carolac of	respiratory a	11031,			Onset and D	veen Death
	Physician /Medical		disease or condition resulting in death)	Seps		of).									Immed:	iate
В	Examiner			Due to (or as	aconseque ntia	nce or):									5 year	re
	w. North	Je.	Sequentially list conditions, I ary, leading to minimum cause. Enter Underlying Cause (Disease or injury	Due to for as		nce of									J year	LS
	outed ansit	Examiner	Cause (Disease or injury that initiated events	Athe	roscle	eroti	c Car	diova	ascul	ar Di	sease				5 year	rs
o,	e execien ar		resulting in death) Last	Due to (or as	a conseque	nce of):										
8760,	The law requires that the death certificate be executed the has been signed by the attending physicien and tage 2 should be detached for use as the buriat-transit	Physician/Medical														
9	leath certifica attending ph I for use as t	/Me	IF FEMALE:	3c. If yes, outcome	of pregnanc	~v							224 Day	o of delive		
Вох	attend for us	lan	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal d	leath 3 □	Ectopic pre					1	Mo	te of delive nth	,	'ear
P.O.	that the de ted by the a detached f	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown												
	s that ned b e deta	by Pi	Part II. Other significant conditions con	tributing to death b	out not result	ing in the ur	nderlying ca	ause give	n in Part I.		23e. Did t	obacco	use cont	ribute to th	e cause of de	ath?
g	w requires that been signed to should be det		N/A								10	Yes 2	X) No	3 Prob	abiy 4 □U	nknown
တ္တ	aw re	plet									24a. Was		24b. \	Were autop	sy findings a	valiable
Ĕ		Completed										rmed?	1 6	death?		
Division of Vital Records,	Attending Physician: The rideath. sctor: After this certificate his by the funeral director, page	Be	25. Was case referred to medical examiner?							of Death (Check only	one)	100 000 1	btox	In In	-1-
) 0	Physic this c	은	1 KLY9S 2 NO	ospital: 1 ☐ Inpatie 28a. Date of Inju	ent 2 EF				4 🗆 1901		e 5 Resi				in-lav home	√'S
n C	ding P. After tuner	lon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	8b. Time of Injury	M	Bc. Injury Work	ai ? ∕es 2.⊟N		3d. Describe	now inju	ry occurr	90		
SIC	Attending Ph ar death. octor: After th by the tuneral	ficat	3 Suicide 6 Could not be	28e. Place of Inj	ury - At hom	e, farm, str					If. Location (Street ar	nd Numb	er or Rura	Route Numb	20 <i>r</i> ,
2	after after Dire	Certification;	4 Homicide determined	building, et	c. (Specify)		,				City or To	wn, Stati	э)			
	spite hours merel y fille		29a. Certifier 1X Certifying Phys	ician: To the best	of my knowl	ledge, death	occurred a	at the tim	e, date and	d place, an	nd due to the	cause(s) and ma	nner as st	ated.	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	ledical	(Check only 2 Medicel Examinations)	and manner st	ated.	n and/or inv				tn occurred	at the time,					
	To I To I	Σ	29b. Signature and title of certifier		. \			License	number			29d. Da	ite signe	d (Month, L	Jey, Year)	
	EE		- My	\	145	•		2890	DC		I)ece	mber	24,	2004	
			30. Name and addless of person who co					Δ37.0	M LT	I.I.o	shingt	- 02	n c	20	015	
	Sta	ate.	Jokh Wiseman, 31. Date filed (Month, Day, Year)	32. Registr	ar's Signatu		-			• , wa	SIITIIS (-0119	D.0	- 40	-	
	Registi	_	DEC 28 200	14 Sens	war	19	Spo	aks	/							

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				State of	Marvlan	d / Depa	artment of I	Health a	nd Mental I	- Ivaien	=-09.15.0 .	
			1 - For State Registrar		,	•	tificate of			Reg. No	2001.	42673
			1. Decedent's Name (First, Middle	le, Last)					2. Date o		y Year	3. Time of Death
	Physici /Medic		Ryan Christoph	er Nette					Dece	nber 2	2, 2004	2:55am M
	Examin		4a. Facility Name (If not institution	n, give street and num	ber)		4b. City, Town,		Death		. County of Deatl	
			12144 Suffolk 5. Social Security Number		7. Age (In yrs. I	ast hirthday)	Gaither If Under 1 Year		4 Hrs. 8 Date o		ntgomer	
п	Funeral Director		157-76-9612	1⊠M 2□F	21	Yrs.	Months Days		Min. (Month	Birth Day, Year,	1983 New	nplace (State or Foreign intry)
	D		Usual Residence of Decedent						ТОСРЕ		1705 1100	•
	arylar show	'n	10a. State 10b. County	,		, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	the M 28a-1	Directo	Maryland Montg	omery	Gait	thersb	10f. Zip Code			10g. Gi	tizen of What Co	
	with Sa or		12144 Suffolk	Torraco			208	78			ted Stat	,
	death	Funeral	11, Marital Status	12. Was Deced		S. 13. \			in? (Specify Yes o Puerto Rican, etc.		14. Race - Amer Black, White	ican Indian,
ဖွ	after or Ite		1 ☑ Never Married 2 ☐ Mar	ned 1 ☐ Yes :	2 🔼 No		I ☐ Yes 2 ☑ No		r derio i noari, etc.	,	Specify:	, 816.
Maryland 21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show Ite Medical Exactinational be notified at	d by	3 Widowed 4 Divorced	Year or Da	tes:		lent's Usual Occu			165 4	W	hite
15	n 72 n nat	Completed	(Specify only highe	nt's Education est grade completed)		(Give	ient's Usual Occu kind of work done DO NOT use retire	during most of	of working	10D. P	(ind of Business/l	ndustry
212	yiene.	omp	Elementary/Secondary (0-12)	College (1-	4or 5+)	Wai	ter			Res	taurant	
פַ	e filec al Hyg l othe vent,	Be C	17. Father's Name (First, Middle,	Last)				18. Mother	's Name (First, Mi	ddle, Maider	Sumame)	
ylar	Menta Menta arkad atic e	To	Christopher B.					·	el B. Pre			
Var	2 sho		19a. Informant's Name/Relations	4	,	1			or Rural Route No	•		
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. By injury or other traumatic event, Ita Medical Examination must be notified at once.	1	Laurel B. Nett	e (Mother	<u> </u>		2 Autumn sition (Name of natory or other pla		Place, Ge		ocation - City or	
nor	ages ont of		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		itale		natory or other pla Cemeter		27: 20	O# Hos		Norr Tomacu
altimore,	nit. P vartme ortan injur injur		21. Signature of Funeral Service			22	. Name and Addre	ess of Facility	DeVol Fu			New Jersey
ä	Dep Imp		V but	(whit		G.	D East Daithersb	eer, Pa	5 ^k 20877e			
П			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that ca	used the death	n. Do not ent	er the mode of dy	ng, such as c	ardiac or respirato	ry arrest,		Approximate Interval Between
	nysician-	11. 1	Immediate Cause (Final disease or condition	a A51	shyxi	ation	1					Onset and Death
	/Medical Examiner		resulting in death)	Due to	r as a consequ	uence of):						
		i i	Sequentially list conditions, if any, leading to immediate	b. Due to (c	or as a consequ	uence of):						
	uted d ansit	Examlner	cause. Enter Underlying Cause (Disease or injury that initiated events	<								
ó	te be executed ysician and ie burial-transit		resulting in death) Last	Due to (c	or as a consequ	uence of):						
8760	# % #	lical		d								
9 XO	death certifica e attending ph ed for use as th	Physician/Med	IF FEMALE:	23c. If yes, outc	ome of pregna	ncv					23d. Date of deli	10P/
Bo	atten I for us	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bit	rth 2 ☐ Fetal	death 3	Ectopic pregnand Other (specify) _	ey			Month Month	Day Year
o.	res that the de signed by the a be detached f	hysl	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkno	wn							
ď.	is thai gned b	by P	Part II. Other significant conditi	ons contributing to dea	ath but not resu	ulting in the ur	nderlying cause gr	ven in Part I.	23e. [oid tobacco	use contribute to	the cause of death?
ğ	w require been sig should b									☐ Yes 2	SKNo 3 □ Pro	bably 4 Unknown
Records,	0 20	Completed							24a. \	Vas an utopsy erformed?	prior to c	opsy findings available ompletion of cause of
		Con							1 🗆 Y		death? 1 ☐ Yes	2014o
Vita	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:		ED/Output	0:	hor	of Death (Check of Sing Home 5		s Dother (See	***
o	<u>a</u> ÷ <u>a</u>	n: To	1 Xyes 2 No 27. Manner of Death	28a. Date o	f Injury	ER/Outpatien 28b. Time of	28c. Inju	4 🗀 19013	-	ibe how inju	6 ☐Other (Speciary occurred	ny)
o o	Attending or death, ector: After by the fune	atlo	1 Natural 5 Pendi 2 Accident invest	Dag A	2, 2004	2:55		Yes 2 N	o han	7/19		
<u> </u>	r Atte	Certification:	3 Suicide 6 □ Could 4 □ Homicide determ	ZNO. PIZCO	of Injury - At ho g, etc. (Specify	ome, farm, str	eet, factory, office		28f. Locali City or	on (S et al Town, State	nd Number or Ru	Sufffe
Ω	oltal o urs aff oral Di			home					Terro	-	ithershu	ng mp
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical		ng Physician: To the I Examiner: On the ba	sis of examinat							
	o the	Me	29b. Signature and title of certific		1) 1/1	1/ /.	29c. Licen	se number		29d. Da	ite signed (Month	, Day, Year)
	:		> Portucia	Tomest	Es /	lag, ni	60 D	5191	6	DE	2c. 22,	2004
	7		30 Name and address of person	who completed cause	of death (Item	23a) (Type,	Print)	11. h	L. 0 11	16 N	1-11.	MAN ARCEN
			31. Date filed (Month, Day, Year	usto Iva	gistrar's Signal	11117 /	KOCKVII	18 VII	(E, 6-10	y Koc	KVIIIE,	2004 MD 20852
	Sta Registr		DEC 28	2004	gratial 5 Signal	B	Sparks					
			-			r .	- 0					

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4

42674

			1109.110.
	Physician	Decedent's Name (First, Middle, Last) CHARLES BUFORD NORTHAM, JR.	2. Dete of Deeth Device 27, Dev2004 Year 12:15PM
	/Medical Examiner	4a Fecility Neme (If not institution, give street end number) 4b. City, Town, 2059 Colona Road Pocomok	or Location of Death e City Worcester
>	Funeral Director	220–68–7799 X × 2 × 49 Yrs.	Hrs. 8. Date of Birth (Month, Day, Yeer) 9. Birthplece (State or Foreign Country) 5/9/1955 Maryland
	Merylend -f show	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Worcester Pocomoke City	10d. Inside City Limits 1 ☐ Yes 2 1 No
	ath with the Meryler 23s or 28s-f show ust be notified at	10e. Street end Number 2059 Colona Road 21851	10g. Citizen of What Country? USA
20	72 hours after death with the Merylend naturel; or items 23s or 28s-f show dies! Exacitive must be notified at eted by Funeral Director		? (Specify Yes or No- uerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0020	5 5	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Correctors Correctors	working 16b. Kind of Business/Industry Construction
land 2	De set H	17. Fether's Neme (First, Middle, Last) 18. Mother's Wathl	Name (First, Middle, Maiden Surname) een Janet Mallon
	nd 2 should alth end Men 27 is marke r traumatic	19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number of	r Rurel Route Number, City or Town, State, Zip Code) COMOKE City, MD 21851
Baltimore,	Peges 1 e nent of Hei nt: if item iry or othe	20a. Method of Disposition 1 Buriel 2 A Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 20b. Plece of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory	Date 20c. Location - City or Town, State 12/29/04 Salisbury, MD
Balti	pemit. Peg Depertment Important: I any Injury o	21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOLLOWAY Melson	Funeral Home, P.A.
		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one ceuse on each line.	Pocomoke City, MD 21851 diac or respiratory arrest, Approximate Interval Between
4	Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death) a. Due to (or es a conseguence of):	Conset and Death
30x 68760,	eeth certificete be executed ettending physician end for use es the bunel-trensit clan/Medical Examiner		
P.O.	v requires thet the deeth cer been signed by the ettendir should be deteched for use leted by Physician/N.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Records,	The law require cate has been signed a specific completed I		24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
Vital Re	icien: The law certificate has rector, pege 2 Be Comp	25. Was case referred to medical 26. Place of	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Death (Check only one)
\geq	2 00	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursin	ng Home 5 Residence 6 □Other (Specify)
ion of	Attending Physic death. actor: Atter this by the funerel di		28d. Describe how injury occurred
Division	tal or Attending P s efter death. al Director: After t led in by the funers Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rurel Route Number, City or Town, State)
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director, After this completely filled in by the funeral Medical Certification: T	29a. Certifier (Check only on a Certifying Physician: To the best of my knowledge, death occurred et the time, date end properties of examiner: On the basis of examinetion end/or investigation, in my opinion, death of end manner stated.	
	Within To the company of the company	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
H	. 1	3). Name end ad tress of person who completed a use of deeth (flum 23e) (Type, Print)	C4 M) 21804
	State Registrar	31. Dete filed (Month, Day, Year) 32. Registrar's Signeture	

			For State Registrar	State of Ma		partment of Fertificate of		-	iene 001	+ 42675
	DI		1. Decedent's Name (First, Middle, L	ast)		18		2. Date of Deat	h	3. Time of Death
	Physici /Medio		Alice Jean ('Reilly				Decembe:	r 23 200	
	Examir		4a. Facility Name (If not institution, ga			4b. City, Town, o	r Location of Death	1	4c. County of De	
			807 Gallop Hill				ersburg	T	Montgo	
ı	Funeral Director		5. Social Security Number 6. 235-68-7948	Sex 7. Age 1 ☐ M 2X F	(In yrs. last birtho	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. 8	Birthplace (State or Foreign Country)
			Usual Residence of Decedent		01			Feb. 11	, 1943 W	
	urylan show	_	10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits
	Ba-fa	Director	MD Montgom	ery		Gaithers	burg			1 X Yes 2 ☐ No
	with th	Dir	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What	
	eath v	Funeral	807 Gallop Hill	. Koad, Apt		208			United S	
(0	r Itan	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No	0	Was Decedent of H If Yes, specify Cuba		o Rican, etc.)	Black, W	merican Indian, hite, etc.
<u>0</u> 3	ral', c	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 📉 No	Specify:		Specify:	White
5	be illed within 72 hours after death with the Maryland ital Hygiene. Ind other than "natural", or Itams 23a or 28a-1 show event, it e Medical Eracult at a ust be rediffed at	Completed	15. Decedent's E (Specify only highest g		16a. De	cedent's Usual Occup ive kind of work done a. DO NOT use retired	ation during most of work	king	16b. Kind of Busine	ss/Industry
12	e filed within al Hygiene. I other than " vent, It e Me	dm	Elementary/Secondary (0-12)	College (1-4or 5+) lif		1)		D	a .
d 2	filed Hygi other ant, I		17. Father's Name (First, Middle, Las			Owner	18. Mother's Nam	ne (First, Middle, N	Retail	Store
au	should be and Mental I s marked o	To Be	James Joseph McG	raw				hy Davis	,	
ary	2 should be and Mental is marked craumatic ever		19a. Informant's Name/Relationship		19b. M	ailing Address (Street Gallop Hil			City or Town, State	, Zip Code)
Σ,	and 2 ealth n 27 i		Wendy Price/ Daug	hter			1 Road,	T-1, Gait	thersburg	, MD 20879
Baltimore, Maryland 21215-0036	ges 1 tof H		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3	☐Removal from State	cemetery,	sposition (Name of trematory or other place	Dece		20c. Location - City	
Ē	it. Pa rtmen rtant: njury		`4 □Donation 5 □Other (Spec	ify)	Metropo	litan ematory	,	.		a, Virginia
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events.	- "	21. Signature of Funeral Service Lice	Offer		22. Name and Address eer Park D	rive, Ga	ithersbu	rg, MD 208	10 East 377
	rnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	a Due to (or as a		201AL			St,	Approximate Interval Between Onset and Death
68760,	iticate be executed physician and is the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a d	consequence of):					
.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of d Month	elivery Day Year
S, G	es that igned b	by P	Part II. Other significant conditions	*	not resulting in the	underlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
ord	w requir been st	ted	Cancer	Cachexia				1 🗆 Yes	s 2 □ No 3 □ I	Probably 4 Unknown
Vital Records,		Completed	25. Was case referred to medical						ed? prior to death?	autopsy findings available completion of cause of
	Attending Physician: r death. ector: Atter this certific. by the funeral director,	o Be	examiner?	Hospital: 1 Inpatient	2 ER/Outpa	ient 3 DOA Othe		th (Check only one	nce 6 ⊡Other (Sp	- Innifed
0	ding Phys h. Atter this funeral di	i.i.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	28b. Time	of 28c. injury	at	28d. Describe hov		вспу)
300	endir sath. or: At he fu	atlc	2 ☐ Accident investigation	n	injui		res 2 □ No			
Division of	I or Attenc after death Director: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could not to determined		/ - At home, farm, (Specify)	street, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
_	To the Hospital or Attenwithin 24 hours after deating the Funeral Director: completely tilled in by the		29a. Certifier 1 Certifying P	hysician: To the best of	my knowledge de	ath occurred at the time	e date and place	and due to the co-	150(s) 20d m	as stated
	To the Hospita within 24 hours To the Funeral completely tilled	edical	(Check only one)	miner: On the basis of e and manner state	xamination and/or	investigation, in my op	inion, death occur	red at the time, dat	te and place, and du	ie to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mor	nth, Day, Year)
	10		1 H-2. HEG	AZIIMY)	240	+10		12-21	1-04
	(-		30. Name and address of person who	completed cause of dea	th (Item 23a) (Typ	e, Print) diuso	- Driv	a from	derile 1	110 Day, Year) 1-04 10 21702
	Sta Registra		31. Date filed (Month, Day, Yeal) NFC 28 2	32. Registrar	s Signature	Sparks				

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1250 December 2004 31 PETERS DONNA JEAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HAGERSTOWN WASHINGTON WASHINGTON COUNTY HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT 15, 19 Birthplace (State or Foreign Country)
 MARYLAND 7. Age (In yrs. last birthday) Social Security Number Days **Funeral** Hours 1 ☐ M 2 🛛 F 217-32-5635 69 Director Usual Residence of Decedent filed withIn 72 hours after deeth with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other then "natural", or Items 23s or 28s-4 show other traumatic event, the Modical Examinations the notified at 1 Yes 2 No Directo HAGERSTOWN MARYLAND WASHINGTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 U.S.A. 11 WEST BALTIMORE STREET, APT. 122 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Specify: Be Completed by 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other then any injury or other traumatic event the Mental Informatic event the Mental Informatic event the Mental Informatic event the Mental Informatic event the Mental College (1-4or 5+) 5+ Elementary/Secondary (0-12) NURSE PUBLIC SCHOOLS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CATHERINE NIELD JOHN DAVID ROWE SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12909 POINT SALEM ROAD, HAGERSTOWN, MARYLAND 21740 JERRY L. ROWE/BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 01/07/2005 5 Other (Specify) BOONSBORO CEMETERY BOONSBORO, MARYLAND 4 Donation 22. Name and Address of Facility 7606 Old national Pike 21. Signature of Fun Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death OVARL Immediate Cause (Final AN **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? ŏ 4☐ Pregnant at time of death 1 ☐ Yes 25 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Wunknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 1 ☐ Yes 2 ☐ No 2 (XNo 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide hours after to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Txpe, Print)

Dr Wasem 1126 Opal Court Hagerstown Marylano 5H-10 31. Date filed (Month, Day, Year) 4 2005 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien [] [] [... 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** VERONICA PUHER 8100 AM DECEMBER 23 2004 /Medical 4a. Facility Name (If not institution, give street and number)
Doctors Community Hospital 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lanham Prince George's 8. Date of Birth (Month, Day, Year) March24, 1922 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex Birthplace (State or Foreign
Country) Months Days Hours Min 1□ M 2√2 F 82 179-14-4366 Director Pennsylvania Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow her traumatic evant, it is Medical Executiver must be notified at Maryland Prince George's Adelphi 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11004 Cherry Hill Road 20783 United States or Itams 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene important: if itam 27 is marked other tha any injury or puber traumatic event, it all angles. Sales Associate retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Firda Anna Kondrat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3899 Windy Trail Cove Bartlett, TN 38135 Christopher Puher -son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cem. 1/4/2005 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DIABETES MELLITUS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the buriat-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physiclan/Medical d IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) 4☐ Pregnant at time of death P.0. the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ should be 1 Yes 2 No 3 Probably 4 Unknown Completed HUPOTH, ROIDISM 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ATRINZ 24a. Was an FBRIL has page 2 autopsy 2 No certificate 1∏ Yes of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 5 Pending investigation 1X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by after 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) HD DECEMBER 25, 2004 D55559 10 Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas E Maslen, M.D. 7525 Greenway Center Dr., #316 Greenbelt, Md. 20770 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State DEC 28 2004 Registrar

			For State Registrar		State of Ma	arylan	d / Depa		t of H	ealth a		lental Hy		nnı		578
	Physicia	210	1. Decedent's Name						-			2. Date of De	ath Day	Yea	3. Time	of Death
	/Medic		ISRAEL	ENRIQUE	PRANDE							Decemb				. Рм
	Examin	er	4a. Facility Name (If n			1 - سد د			Town, or	Location of	of Death			County of De		
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ı	Physici		Docedent's Name (First, Middle, Last) DOLLY VIKTORIA	POZNERZOI	N			2. Date of Death Month December		3. Time of Death 2004 11:08A M		
	/Medic Examin		4a. Facility Name (If not institution, give si			4b. City, Town, o	r Location of Deat	J	4c. County of [
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	Funeral Director		370.40.4980	M 2⊠F 7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day, Y		Birthplace (State or Foreign Country) Cermany		
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of	Phys r this ral dir	. To	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a, Date of Injury	ER/Outpatier			ome 5 X Residence		Specify)		
O	Attending Physician: r death. ector: After this certific: by the funeral director,	tlon	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year,) Injury	Wor	k? Yes 2 □ No		,,			
Division of		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office		28f. Location (Stree City or Town, S		r Rural Route Number,		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical		ician: To the best of my left: On the basis of exam and manner stated.								
١	To the To the comple	Σ	29b. Signature and title of certifier			29c. Licens D-328			Date signed (Mccember 2			
,	U	3	30. Name and ad less of person who cor	npleted cause of death (I	tem 23a) (Type.			De	CEMBEL 2	.7, 4004		
			M. Wageed Kahn, M		, , , , ,		Wheaton,	Maryland	20902			
	Sta Registr		31. Date filed (Month, Day, Year) DEC 28 2004	32. Registrar's Sig	gnature 🛌	Sparks						

			State of Manifold / Den		•	
			1 _ State	eartment of Health and Me ertificate of Death		0001
			1. Decedent's Name (First, Middle, Last)		Reg 2. Date of Death	. No. UU 4 4 2 6 8 0
	Physicia	an			December	Day Year
	/Medic Examin		Edgar Raymond Parkison 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Decembe	4c. County of Death
	Examin	eı	Montgomery General Hospital	01 ne y		Montgomery
ī	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth	Q Righalana (Ctata or Famina
	Director		552 40 2537 1 ^{12€M 2□ F} 73 Yrs.	Monais Days Hours Min.	July 20	1931 Kansas
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Maryl fsho	tor	Md. Montgomery Rockv	ille		1 ☐ Yes 2 ⊠No
	r 28a	Director	10e, Street and Number	10f. Zip Code	100	. Citizen of What Country?
	ba filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itams 23a or 28a-f show event, the Medical Erain arminal be rediffed at		16560 Emory Lane	20853		United States
	ams	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	rify Yes or No-	14. Race - American Indian, Black, White, etc.
20	or It	by Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2, ☒ No Specify:	•	Specific
2-00-c	hour tural		Nor Call	edent's Usual Occupation	16	b. Kind of Business/Industry
<u>.</u>	in 72 n "na nedic	plet	(Specify only highest grade completed) (Give	e kind of work done during most of workin DO NOT use retired)	g	o. Nind of Edamess/ridus(ry
7	d with giene or the	Completed	Elementary/Secondary (0-12)	emetry Engineer		Communications
and	a filed al Hygi I other vent, I	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name		
Na	2 should ba and Mental Is marked eumatic ev	To	Horace Downey Parkison	Viviar		Alspach
la	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic evone.		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mail Judith M. Parkison / Wife 165	ling Address <i>(Street and Number</i> o <i>r Rural</i> 60 Emory Lane, Rock	Route Number, C	City or Town, State, Zip Code)
e)	1 and Healtl em 2			position (Name of Damatory or other place)		c. Location - City or Town, State
5	ages int of t: F if			ematory or other place) emetery 12/28		Brookeville, Md.
saitimore	nit. Prartme orten injur			22. Name and Address of Facility Muriel H. Barber F		
ñ	Per Per Per Per Per Per Per Per Per Per		who hate M-00470	Muriel H. Barber H. P. O. Box 5038, L	uneral f avtonsvi	lome 11e, Md. 20882
	10 8		23a. Pall. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause or sact line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	enterenia.	Dacto	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	7		47/100
	LAAIIMIEI	_	Sequentially list conditions, and the sequence of the sequence			
	ted	nine	cause. Enter Underlying Cause (Disease or injury			
,	be executed ician and burial-transi	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):			
20	0 5 0	cai	d.			
Q	death certificate t e attending physion of for use as the b	hysician/Medi	IE FEMALE.			
gox	th ce tendi	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	☐Ectopic pregnancy		23d. Date of delivery Month Day Year
S.	ne dea the at	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Month Day 16a1
7.	w requiras that the de been signed by the s should be detached	₾.	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	co use contribute to the cause of death?
ds,	uiras I signe Id be	d by		, ,	1 ☐ Yes	2 No 3 Probably 4 □Unknown
cord	law req as beer 2 shou	ompleted			24a. Was an	24b. Were autopsy findings available
ğ	o – e	ошь			autopsy performe	prior to completion of cause of
VItal	icien: Th certificate rector, pag	3e C	25. Was case referred to medical	26. Place of Death		10 10 20 10
010	hysicien: nis certific I director.	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing Hom	e 5 🗆 Residend	e 6 □Other (Specify)
	Attending Physicien: sr death. actor: Attar this certific by the funeral director.		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year)	Work?	3d. Describe how	injury occurred
UIVISION	tendi leath. tor: A the fu	cati	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 289 Place of Injury. At home form of	M 1 Yes 2 No	26 Landing (Carr	And Museline of Court Court About
₹	or At after of Dirac in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	теет, тастогу, оптсе	City or Town,	at and Number or Rural Route Number, State)
_	spitel nours neral	alC	29a. Certifier Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, ar	nd due to the cau:	se(s) and manner as stated.
	To the Hospitel or Attending Physwithin 24 hours after death. To tha Funeral Diractor: Attar this completely filled in by the funeral di	edical	(Check only 2 Medical Examiner: On the basis of examination and/or in one)	nvestigation, in my opinion, death occurred	d at the time, date	and place, and due to the cause(s)
	To the within To the Comp	Me	29b. Signature and tritle of Certifier	29c. License number	29d	Date signed (Month, Day, Year)
	1011		I MORE I AGOSE MI	12/6458	the	24,0004
	(- ()		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	1	11. 2001 200
	Ch		31. Date filed (Month, Day, Year) 32/Plegistrar's Signature	TOZEKGIA TIVENUG	VINOY!	MARY CAM)
	Sta Registr		DEC 28 2004	sporker		

			1 - For Stata Registrar	State of Ma	ryland / [Depa <i>Cer</i>	rtment of H tificate of I	lealth a D <i>eath</i>	and Mer		gierie Reg. No		42681
			1. Decedent's Name (First, Middle, La	st)					2.	Date of De	ath		3. Time of Death
	Physicia /Medic		Katherine I	Elizabeth	Quin	n			De	Month ecembe	er 2	5 2004	1:50 A ^M
	Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, or	Location o	of Death		4c	. County of Dea	ath
			Shady Grove Adv				Rockvi					Montgom	
	Funeral		5. Social Security Number 6. S	ex 7. Age □M 2XIF	e (In yrs. last bir 91	thday) Yrs.	If Under 1 Year Months Days	If Under:	Min.	Date of Bir (Month, Da	ı <i>y, Year)</i>	9. Bi	rthplace (State or Foreign country)
	Director		Usual Residence of Decedent		71	113.			At	1g. 10	b, 1	913 Mas	sachusetts
	yland How		10a. State 10b. County		10c. City, Tow	n or Lo	cation						10d. Inside City Limits
	a-f sh	tor	Maryland Montgome	ery	Gaithe	erst	urg						1 XYes 2 □ No
	or 28	lre	10e. Street and Number				10f. Zip Code				-	tizen of What C	•
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show I'm Medical Erar, are must be notified at	Funeral Directo	221 Booth Stree				2087					ted Sta	
	ar dea	nne	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	ispanic Ori ın, Mexican	gin? (Specify), Puerto Ric	Yes or No an, etc.))-	14. Race - Am Black, Whi	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2X N If Yes, Give Year or Dates:	10	1	☐ Yes 2X No	Specify:				Specify: W	hite
21215-0036	2 hou	ted	15. Decedent's E	ducation	16a.	. Deced	ent's Usual Occup	ation			16b. K	and of Business	
215	hin 7:	Completed	(Specify only highest gra	College (1-4or 5	+)	life. L	kind of work done of NOT use retired	during mosi i)	t of working				
21	e filed within It Hygiene. other than "	Con		4		ach	er						Education
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last,						er's Name (F			Sumame)	
<u>Y</u> a	2 should be and Mental is marked craumatic even	ဥ	James Marr						len Re				
Maryland	12 sh h and 7 is n traun		19a. Informant's Name/Relationship (Philip Quinn /	**	1		g Address <i>(Street</i> Bostwick						nd 20878
e,	Health at tam 27 is tam 27		20a. Method of Disposition	5011	20b. Place of	Dispos	sition (Name of		Date			ocation - City or	
altimore,	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. If a Medical Evertified at once.	i	1 N Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif			-	natory or other plac Cemeter		Decemb		3.5		
Ħ	ourtme	li	21. Sign Jure of Funeral Service Licer				Name and Addre		30, 2			liord, I	Massachusett
ă	Per Per Per Per Per Per Per Per Per Per		Jam C	Wh		10	E. Deer	Park				urg, M	20877
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do i	not ente	er the mode of dyin	g, such as	cardiac or re	spiratory a	rrest,		Approximate Interval Between
Ų,	Pnysician		Immediate Cause (Final disease or condition	a Sepsis									Onset and Death 24 Hours
	/Medical Examiner		resulting in death)		a consequence	of):							
	LAGITIMIE	_	Sequentially list conditions,	b. Aspirat	ion Pne		nia						4 Days
	per is	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury	Due to (or as	a consequence	OI).							
	al-trai	Examine	that initiated events resulting in death) Last	c. Due to (or as a	a consequence	of):							
68760,	ficate be executed physician and is the burial-transit	edical		d									
Box	death certifi e attending id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 🗆	Ectopic pregnancy	,				23d. Date of de	
ю. В	0 0 0	sici	in the past 12 months? 1 ☐ Yes 2 🕅 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 🗆	Other (specify)					Month	Day Year
<u>G.</u>	iaw requires that the de as been signed by the a 2 should be detached f		Part II. Other significant conditions of	contributing to death bu	ut not resulting is	n the ur	iderlying cause gry	en in Part I.		23e. Did t	obacco i	use contribute t	to the cause of death?
ds,	signed d be del	d by		3	•		,			1 🗆 '	Yes 2	□No 3□P	robably 4 🛣 Unknown
COL	w requir been s should	lete								24a. Was	an	24b. Were a	utopsy findings available
Re	9 2 9	Completed								autor perfo	osv	prior to	completion of cause of
of Vital Records,	ician: Th certificate rector, pag	0	25. Was case referred to medical					26. Place	of Death (C			1 1 19	s 2 No
Ž	tending Physician: leath. for: After this certifica the funeral director.	To B	examiner? 1 🗌 Yes 2 🏋 No	Hospital: 1 X Inpatie	nt 2 ER/Ou	utpatien	3 DOA Oth	or				6 ☐Other (Spe	ecify)
0			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injur (Month, Day		Time of Injury	28c. Injun Wor	y at k?	28d	. Describe	how injui	ry occurred	
Sio	Attending r death. sctor: After	catle	2 Accident investigatio					Yes 2 🔲					
Division		Certification:	4 Homicide determined		iry - At home, fa c. (Specify)	ırm, stre	et, factory, office		28f.	City or To			tural Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Directompletely filled in by		29a. Certifier 1 X Certifying Pt	nysician: To the best of	of my knowledge	e death	occurred at the tin	ne date an	d place, and	due to the	cause/s) and manner a	s stated
	24 hos 24 hos a Fun etely	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination an	d/or inv	estigation, in my o	pinion, dea	th occurred a	at the time,	date and	d place, and du	e to the cause(s)
	To tha I within 2 To tha I complet	Me	29b. Signature and title of certifier	4			29c. Licens	e number			29d. Da	te signed (Mon	th, Day, Year)
)	10		I christe le	sporte			615	49			Dec	ember 2	5, 2004
	("		30. Name and address of person who	completed cause of de						-			
			Christine Lepou				al Cente	r Dri	ve Ro	ockvi	lle,	Maryla	nd 20850
	Sta		31. Date filed (Month, Day, Year) DEC 28 20		ar's Signature	15	Sign Frederica	1					
	Registr	20											

			1 = For State Registrar	State of Maryl	and / Depa	artment o		and M		_) L	42682
	Physici		Decedent's Name (First, Middle, Last) STEVEN LON	GWORTH REIS	ERT				2. Date of Death Month	Day	Year 04	3. Time of Death
I	/Medio Examir		4a. Facility Name (If not institution, give s DORCHESTER GENER	street and number)		4b. City, To	wn, or Location	DGE		4c. County	of Death	TER
	Funeral Director		5. Social Security Number 101-40-5313 Usual Residence of Decedent	7. Age (In) 7. Age (In)	vrs. last birthday) Yrs.	If Under 1 \ Months D	Year If Under Pays Hours	r 24 Hrs. Min.	8. Date of Birth (Month, Day, SEPT 13	1948	9. Birthp Coun NE	place (State or Foreign htry) W YORK
	Maryland -f show	tor	10a. State 10b. County MD DORCHES		City, Town or Lo						1	0d. Inside City Limits 17 Yes 2 □ No
	h with the	ai Direc	10e. Street and Number 520 GLENBURN AVE			10f. Zip Co	21613		10	g. Citizen ol \	What Coun	itry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumatic event. Ite Medical Exartance uset by indifficult	by Funeral Director		12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedentif Yes, specify			cify Yes or No- Rican, etc.)	Btac	e - Americ ck, White, v: WHI	etc.
21215-0036	within 72 hou ane. then "netur to Maid call is	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	DO NOT use r	done during mo retired)	st of workir	ng 1	6b. Kind of B		
Maryland 2	uld be filed v dental Hygie rked other i tic event, tt	To Be Co	12 17. Father's Name (First, Middle, Last) STANLEY REISERT	5	MUA	<u> IINISTR</u>	18. Moth		(First, Middle, M	aiden Suman		RTATION
	t and 2 sho Health and N Sm 27 is ma ther treums		19a. Informant's Name/Relationship (<i>Ty</i>) BARBARA A. REISER 20a. Method of Disposition	T/WIFE		CLAIB	ORNE RI) CL	I Route Number, A I BORNE		24	
Baltimore,	permit. Pages Department of I Importent: If ite any injury or of ance.		1 ☐ Burial 2 🖾 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	emoval from State	cemetery, cre HESAPEAL	matory or othe CE CREM 2. Name and A	r place) [ATION Conditions of Facilities of Facilities Conditions of Fa	CTR 12	2-21-200	4 ST	EVENS	SVILLE, MD
a I	9 9 6 6		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused the cause on each line.					N & NEWN EASTON, r respiratory arre		EBAL	Approximate Interval Between Onset and Death
8760,	/Medical Examiner physician and physician and the priral-transit	ilcai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniteritying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a con Due to (or as a con Due to (or as a con	384481108 01).	ial f	aile	r				
P.O. Box 68	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pregr Other (speci				23d. Dat Mo	te ol delive nth	ory Day Year
	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	nderlying caus	se given in Part	l.		acco use cont		ne cause of death?
il Records,	The te hage	Completed							24a. Was an autopsy perform	ed?	prior to con death?	psy findings available impletion of cause of
Division of Vital	iding Physicien: Th. th. After this certificate funeral director, p.	To Be	27. Manner of Death 1 Natural 5 Pending	lospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o		Othon	lursing Hon	(Check only one ne 5 ☐ Resider 28d. Describe how	ice 6 Oth		9
Divisi	el or Attending s after death. I Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, larm, str ecify)	reet, factory, or		-	28f. Location (Stre City or Town,		er or Rura	l Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C		sicien: To the best of my ner: On the basis of exam and manner stated.								
ŀ	To the within 2. To the Complete	M	29b. Signature and title of certifier	M MD	Item 23a) (Type,	29c. L	cense number	659	29	d. Date signed	Month, I	Day, Year)
			30. Name and address of person who co	mpleted cause of death	Item 23a) (Type,	Print) X/6	MD	-2/	613			
	Sta Regista		31. Date liled (Month, Day, Year)	32. Registrar's S	ignature	5 1 2 m	1					

				For State Registrar	State of	•	epartment of Certificate of	f Health and North		giene	L 1.200
_		Physic /Medi		Decedent's Name (First, Middle, La	^{st)} Benjami	n	REINKEL		2. Date of Dea Month Decembe	er 26, 200	3. Time of Death O
		Exami		4a. Facility Name (If not institution, giv Suburban Hospit		ər)	Beth			4c. County of E	
		Funeral Director			Sex 7. I M 2 F	Age (In yrs. last birtho	Months Da		8. Date of Birt (Month, Da March 2	y Year) 1, 1915	Birthplace (State or Foreign Country) New York
		Maryland f show	tor	10a. State 10b. County Maryland Montgot	merw	10c. City, Town o					10d. Inside City Limits 1 ☐ Yes 2√2 No
		with the 3a or 28a	Funeral Directo	10e. Street and Number 6111 Montrose Ro			10f. Zip Cod	0852	1	10g. Citizen of Wha	t Country?
	36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury gether traumatic avant. The Medical Exactiver must be 1 cultified at once.	by Funera	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 XYes 2 If Yes, Give	s? No	I3. Was Decedent of If Yes, specify C	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No <i>Specify:</i>		14. Race - A Black, V	American Indian, Vhite, etc. White
	215-0036	hin 72 hour e. In "natural Medical E.	Completed b	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		16a. De	ecedent's Usual Oc ive kind of work do e. DO NOT use re	cupation ne during most of work tired)	sing	16b. Kind of Busine	
Re	ind 21	be filed with tall Hygiene of other the avant. It is	Be Com	12 17. Father's Name (First, Middle, Last)	Mail	Handler	18. Mother's Nam	e (First, Middle,	US Govern	ment
ichny	Maryland	2 should and Men is marka raumatic	7	Isadore Rein 19a. Informant's Name/Relationship (Type, Print)	1		eet and Number or Rur		or, City or Town, Stat	
al Ex	iore, l	iges 1 and of Health: If itam 27		Eva Reinkel, Wi 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Removal from Sta	20b. Place of Di cemetery,	sposition (Name of crematory or other)	place)	Date	20c. Location - City	or Town, State
Media	Baltimore,	permit. Pa Departmer Important any injury once.		' 4 □ Donation 5 □ Other (Special Service) 121. Signature of Fune al Service 122.		>	22. Name and Ad Torchins	etery 12/29 dress of Facility ky Hebrew I	uneral		
Peresol by Medical Examine	1	Physician		23a. Part1 Ento the disease, or comshock, heart failure. List only	one cause on each	sed the death. Do not line.	254 Carro enter the mode of o	oll St., NW dying, such as cardiac	I, Washi or respiratory ar	ngton, DC rest,	Approximate Interval Between Onset and Death
(eles		/Medical Examiner	ı	disease or condition resulting in death)	a Sepsi	S as a consequence of):					_ l Dav
0815	8760,	ate be executed thysician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of king) that initiated events resulting in death) Last	с.	as a consequence of): as a consequence of):					
2/20/04	.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death	3 □Ectopic pregna 5 □ Other (specify,			23d. Date of Month	delivery Day Year
-	rds, P	w requires tha been signed I should be det	b	Part II. Other significant conditions of Congestive Heart		but not resulting in th	e underlying cause	given in Part I.			e to the cause of death? Probably 4 🕍Unknown
Brigamin	al Record	The ate h page	Completed						24a. Was a autops perfor	sy prior med? death	autopsy findings available to completion of cause of ? 'es 2 \(\) No
inkel, Beni	ivision of Vital	or Attending Physician: The iffer death. Diractor: After this certificate in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1 X Yes 2 No 27. Manner of Death 1 X Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Place of		e of y M 1	njury at Vork? ☐ Yes 2 ☐ No	me 5 ☐ Reside 28d. Describe he	ence 6 Other (Sow injury occurred	Specify) Rural Route Number,
Ki		pital urs a aral I	edical Ce	29a. Certifier 1 Certifying Pt (Check only one)	ysician: To the be nîner: On the basis and manner	of examination and/o	eath occurred at the rinvestigation, in m	e time, date and place, y opinion, death occurr	and due to the c	ause(s) and manner ate and place, and c	as stated. due to the cause(s)
		To tha Hos	Me	29b. Signature and ritle of certifier	Q	N	29c. Lice	D 37891		9d. Date signed <i>(Mo</i>	onth, Day, Year)
		>		30. Name and address of person who A. Rajvanshi, M				, #409, Roc	kville,	MD 2085	2
		Sta , Regist		31. Date filed (Month, Day, Year) DEC 28 2		strar's Signature	Span	KN			

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 5:00 A^M GERARD JOSEPH RAMSPACHER 12 26 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**M 2□ F Months Yrs. Director 050-46-5673 12/28/1951 PA 52 Usual Residence of Deceden 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show other traumatic event. The Medical Examiner must be notified at 1 XYes 2 □ No Director MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 209 N. 1st St. or Items 23a 21842 USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. and 1 ferms 27 ie marked other than "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Amed Forces:

1 DXYes 2 No
If Yes, Give
Year or Dates: 1974-94 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Army Major **US** Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Joseph Ramspacher Regina Durross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steve Ramspacher 622 Maple Hill Lane Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1/3/05 1 ☐ Burial 2X Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If ony injury or Frankford, DE Cape Henlopen Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facili The Burbage Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? detached for Dav 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 ■Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an ector, page 2 autopsy performe 1 Yes 2 No Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3□ DOA tuneral dir Medical Certification: To oţ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier etely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death/(Item 23a) (Type, Print) Durk. 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State 29 2004 Registrar

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Ramspocher,

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12- 24 - 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 12:47 AM 12 31 Aaron Vincent Ridgell, Sr. 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE MEDICAL CENTER BALTIMORE NA If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, March 6 6. Sex Birthplace (State or Foreign
Country) **Funeral** 1**X** M 2□ F Days Hours Min. Yrs. Director 1940 Maryland 220-38-4286 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner quat be notified at 1XYes 2 ☐ No Directo Maryland Caroline Denton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after deeth with 21629 U.S.A. 524 Market Street Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1958-62 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Electric Company Estimator I Pages 1 and 2 should be filed we renent of Health and Mental Hygie rent: it item 27 is marked other tourry or other treumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ernest Ridgell Florence Ridgell Ridgell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 524 Market Street; Denton, MD 21629 Nancy L. Ridgell/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit Pages 1 Department of H Importent: it its any injury or ot ance. 1 Burial 2 Deremation 3 Removal from State
4 Donation 5 Other (Specify) St. Michaels Cemetery 01/11/05 Ridge, Maryland 22. Name and Address of Facility Fleegle and Helfenbein Funeral 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Added To Sease Home; 106 W. Sunset Ave; Greensboro, MD 21639 Approximate Interval Between Onset and Death **Physician** Ovorany resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical anding physical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by to d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t irector, page 2 s autopsy performed 2 No 1 Yes 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 교 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28b. Time of Certification: After 5 Pending 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

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2005

PESSOA

29b. Signature and title of certifies

IKKITA

13. Speciel

10 N. Greene

29c. License number

St.

Baltmore, ND

29d. Date signed (Month, Day, Year)

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			1 - For State of Marylan		artment rtificate			and M		iene 109. N2 0	04	426	86
	Physici /Medio	cal		nglex		-		(5 4)	2. Date of Dea Month December	Y BI	Year 2004	3. Time o	
1	Examir Funeral	ier	4a. Facility Name (If not institution, give street and number) Washington County Hospital 5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	Ha g	gers 1 Year	If Under		8. Date of Birth	Wash	ingto 9. Birth	n place (State o	or Foreian
	Director		Usual Residence of Decedent	Yrs. Y, Town or Lo		Days	Hours	Min.	8. Date of Birth (Month, Day Feb. 19	, 1923	Peni	nsy1va	nia
	the Marylan r 28e-f show notified st	rector		erstow		Code				l 0g. Citizen of			2X No
36	is 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "natural", or iteme 23a or 28e-1 show other traumatic event, II a Madical Examinat must be notified at	by Funeral Director	810 Medway Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U. Armed Forces? 1 XYes 2 No. If Yes, Give WWII. Year or Dates:	S. 13.1			spanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		ace - Ameri ack, White,		·
21215-0036	ed within 72 hor giene. er than "naturi ; the Medicelli,	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0-7 0	16a. Deced (Give life. l	kind of wor DO NOT us	k done d e retired)	uring most	t of worki	ing	16b. Kind of I	Business/Ir	dustry	
Maryland	should be filed within and Mental Hygiene. s marked other than "tumatic event, II:e Men	To Be (John Spangler			(0)			Sadie	Sn	nith	2 / 1	
Baltimore, Mar	permit. Pages 1 and 2 she Department of Health and importent: if item 27 is ma any injury or other trauma		1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State	789 Place of Dispo emetery, crem gerstor	Jeffe sition (Name and or or or or or or or or or or or or or	rson her place emate	Blvc ory s of Facility	Jan. 200	2.	own, Ma 20c. Location Hagers Funeral	rylar City or Town,	own, State Mary1	and
8760,	cate be executed // Medical Examiner and physicien and the burial-transit	Ical Examiner	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence of th	STRUC uence of):								Approximatinterval Bat Onset and I	Death
P.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of december 10 december 20 decemb	Ideath 3□	Ectopic pre					1	ate of delivi	-	Year
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Division of Vita	To the Hospitel or Attending Physician: Th within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, pag	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ER/Outpatien 28b. Time of Injury	28 M	Bc. Injury Work 1 🗆 Y	r: 4 □ Nui	rsing Hor	n (Check only or me 5 ☐ Reside 28d. Describe he 28f. Location (Si City or Town	ence 6 Ot	rred		iber,
	To the Hospitel or Attenwithin 24 hours after deation to the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my kno 2 Medical Exeminer: On the basis of examinal and manner stated.	tion and/or inv	vestigation,	in my op	inion, deat	noccurr	ed at the time, d	ate and place	, and due to	o the cause(s	
)	Total withi Total comp	Mc	29b. Signature and title of certifier M 30. Name and address of person who completed cause of death (Item)	29c.	License	number	81	2	9d. Date signe	ed (Month,	Day, Year)	
5+	Sta Registr	-32	30. Name and address of person who completed cause of death (Item KODUAH PEPRAH 382 31. Date filed (Month, Day, Year) AN 0 4 2005 32. Registrar's Signa	S. CL ture	ever	AN.	DA	(vE	, HAG	ERSIC	SWN	mb 2	1746

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year David McClellan Shirley, Sr. 30 ecomber 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hagerstown
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Washington County Hospital
5. Social Security Number 6. Sex 7. A Wash ington

9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 11XM 2□ F Months Yrs. Director 220-30-9436 June 18, 1933 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits er than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 X No Directo Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15540 Clear Spring Road 21795 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 🛛 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7. th and Mental Hygiene. 7 Is marked other than "no Elementary/Secondary (0-12) College (1-4or 5+) Custodian 10 Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Jacob Shirley, Sr. Elsie Izora Pierce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 Is: ury or other trau Ella J. Shirley (Wife) 15540 Clear Spring Rd. Williamsport, Maryland 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or ¹ 4 □ Donation 5 □ Other (Specify) Greenlawn Mem. Park | Jan. 3,2005 Williamsport, Maryland Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, Maryland 21795 Signatu of Funeral Solvice Lices Porty Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Interestidial 20 years disease or condition resulting in death) /Medical Examiner we ariway does Obstruc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of): Box 68760 physician Physician/Medical as the t IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No Y Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1□Yes 2√QNo 1 Tyes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1r¶Natural 2 ☐ Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral 6 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D28365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAW D. SHAM. 368 Hagestown MD 21740 3H-7 null 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar		State	of Ma	ryland	-	artmen rtificat			and M	ental Hy	gienę Reg. Ne	000) L ₁	426	88
	Dhysisi		Decedent's Name (First, M.	iddle, La:	st)								2. Date of Dea			Vear	3. Time of	Death
	Physici /Medic		Edward J.	Spil	lett J	r.						I	Decembe	r 24	20)04 004	6:10	АМ
1	Examin		4a. Facility Name (If not instit						,		Location o	f Death		4c.	County o	of Death		
			Shady Grove								ille					mery		
	Funeral Director		5. Social Security Number 099-38-0586		ex Mi 2□ F	7. Age	58	ast birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da Aug. 5,	1946		9. Birthp Coun NY	lace (State o try)	r Foreign
	and		Usual Residence of Deceden 10a. State 10b. Cou			1	10c. City	, Town or La	cation							1	0d. Inside Cit	ty Limits
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03	72 hours after death with the Maryland natural, or Items 23a or 28a-1 show Jital Examinat must be notified at	d b	3 Widowed 4 Divo	ced	If Yes, G Year or	Dates:			1 ☐ Yes	2 XI No	<i>Specify:</i>				Specify:	Wh	ite	
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination at the rediffied at once.		19a. Informant's Name/Relat Jean K. Spill		**			1	-				<i>R</i> ou <i>te Numb</i> e ad, Ger				,	
	1 and Healt em 2		20a. Method of Disposition	.666/	WITE		20b. Pl						ate Ger				wn, State	
Baltimore,	Se in to in to in to in the interest in the interest		1 X Burial 2 ☐ Cremat			State	i	ace of Dispo metery, crer			" I	Decem						
菲	it. Partmer rtant njury		*4 ☐ Donation 5 ☐ Other 21. Signature of Euneral Sen				Ass	umptic			У	30, 2	2004	Syr	acus	e ,	New Yo	ork
Ba	perm Depa Impo any i		21. Signature of Puneral Serv	1 12	(2)			T T	eer 1	ark.	Drive	y Dev	ol Fun	buro	HOM.	1e, 1	U East 77	
		-	23a. Part1. Enter the disease	e or com	nlications that	caused	the death						- 73		,		Approximate	
	/Medical Examiner whysician and prival-transit the burial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underwind Lause (Disease or injury that intitated events resulting in death) Last	{	c. /	2	consequence of conseq	4/	s/	101,	let lu	to e	soct	761	,		Very	ns
P.O. Box 68760,	death certific e attending p ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			birth :	of pregnar 2	death 3]Ectopic pr] Other (sp					2	3d. Date Mont	of delive	•	ear
	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant con	ditions c	ontributing to	death bu	t not resu	lting in the u	nderlying c	ause givei	n in Part I.		23e. Did to	bacco u	e contrit	oute to th	e cause of de	eath?
of Vital Records,	w require: been sig should b	od b											1 □ Y	'es 2[]No 3	3 🗌 Proba	ably 4	nknown
00	s been s should	Completed											24a. Was a		24b. W	ere autop	sy findings a	vallable
Re	9 4	mo											autop	med	de	ath?	npletion of ca	use of
ta	ician; Th certificate rector, pag	O	25. Was case referred to me	dical	-						26 Place	of Death	1 ☐ Yes (Check only or	2 No		⊒ Yes	2□ No	
\geq	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ◯ No		Hospital: 1	Inpatier	nt 2 E	R/Outpatien	t 3 DC	A Other	-		ne 5 ☐ Resid		Other	(Specify)	
	Attsnding Ph r death. ector: Alter thi by the funeral		27 Manner of eat 1 Natural 5 Pe 2 Accident inv	nding restigation		of Injun		8b. Time of Injury		8c. Injury Work		2	8d. Describe h				,	
Division	il or Attsndi after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Co	ould not be termined	280. Plac		ry - At hor (Specify,	me, farm, str	eet, factory	, office		2	8f. Location (S City or Tow		Number	r o <i>r Rural</i>	Route Numb	per,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edlcal C	29a. Certifier (Check only one) Cert	ifying Ph ical Exar	niner: On the	e best of basis of nner stat	examinati	vledge, death ion and/or inv	occurred vestigation	at the time in my opi	e, date and inion, deat	place, a	nd due to the o	ause(s)	and mani place, an	ner as stand due to	ated. the cause(s)	
1	To th within To th compl	Me	29b. Signature and title of cer	pifie)	Q.	17	290	License	number 33	76		29d. Date	signed	(Month, C	Day, Year)	Veni
7	10		30. Name and address of per	son who	completed on	ISA of do	ath /lta	23a) (Tuna	Print)		//	-	1 1-	((277/	1012	VI	-/
	•		William Dool						•	D 0	okari 1	110	MD 20	850			,	
	Sta	te	31. Date filed (Month, Day, Y				r's Signat		-			, ۲۲	FID ZU	0.50				
	Registr		nec 2	8 20	04 2	Epel	مصو	19	1900	rks								

		Į.	For Stata Registrar	State of Maryland		artment of I rtificate of			ene . N2 0 0 L	42689
	Physici		1. Decedent's Name (First, Middle, Last) Mildred Thelma S	Souder				2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give s Doctors Community	treet and number) Hospital		4b. City, Town, C	or Location of De		4c. County of Death Prince Geo	
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. II		If Under 1 Year Months Days	If Under 24 H Hours Mi		9. Births 926 Vir	place (State or Foreign ntry) ginia
	and w.		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation				Od. Inside City Limits
	Manyi B-f eho	tor	Maryland Prince Ge	eorge's Col	llege 1	Park				1 X Yes 2 □ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 5204 Palco Place			10f. Zip Code 2074	10	100	g. Citizen of What Cour United Sta	•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 le markad other then "naturel", or Items 23a or 28a-f ehow mithortent: If item 27 le markad other then "naturel", or Items 23a or 28a-f ehow my injury or other treumatic event. I'm Medical Eracii art must be rectified at once.	by Funer	11. Marital Status 1 Never Married 2 Married 3 Nowled 4 Divorced	2. Was Decedent Ever in U.s Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 X No	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White, Specify: W	
2-00	72 hou	eted	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occu	pation	yorking 16	6b. Kind of Business/In	dustry
21215-0036	d within giene. er then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Cler	kind of work done DO NOT use retire ical	d)		Arbitron	
Maryland	uld be file Aental Hy rkad oth tic event	To Be (17. Father's Name (First, Middle, Last) Frank	Kidwell	_		18. Mother's N Ruth	ame (First, Middle, Ma	aiden Sumame) Beach	
	and 2 should salth and Men n 27 le marka lar treumatic	Ċ	19a. Informant's Name/Relationship (Type Shirley Souder –da		19b. Mailii 730 I	ng Address <i>(Street</i> Davol Roa	and Number or and Steve	Rural Route Number, C NSVille, Ma	City or Town, State, Ziparyland 216	Code) 566
Baltimore,	Pages 1 a		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)	amount from State	emetery, crei	sition (Name of natory or other pla			oc. Location - City or To linton, Mar	
Baltir	permit. F Departme Importer any injur		21. Signature of Funeral Service License							rland 20705
100	Enysician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Motastati	. Do not ent	er the mode of dyi	ng, such as cardi	ac or respiratory arres	ville, Mary	Approximate Interval Between Onset and Death 4 Years
	Examiner		Sequentially list conditions	Due to (or as a consequ	ience ot);					
	and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
8760,	cate be axecuted physician and the burial-transit	dical E	L	Due to (or as a consequ	ience or).					
.O. Box 6	death certifi e attending d for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnant of the second of the secon	death 3[Ectopic pregnanc Other (specify)	у		23d. Date of delive Month	ery Day Year
<u>α</u>	uires that signed by Id be deta	by	Part II. Other significant conditions con	tributing to death but not resu	ılting in the u	nderlying cause gr	en in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to the	ne cause of death?
Records,	The law requires that the rate has been signed by the page 2 should be detached.	Completed	`					24a. Was an autopsy performe	prior to co death?	psy findings available impletion of cause of
Vital		BeC	25. Was case referred to medical examiner?					eath (Check only one)		
of	Phys rthis ral dii	۲.	1 Yes 2 No H	ospital: 1X Inpatient 2 I I 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Inju Wo	ry at rk?	Home 5 Resident	ce 6 Other (Specify injury occurred	y)
Division	Atten r deat actor: by the	Certification	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str		Yes 2 □ No	28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
	Hospita 4 hours Funerel iely fillec	edical C	29a. Certifier 1X Certifying Phys (Check only onl) Madical Examin	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, deatl	n occurred at the ti vestigation, in my o	me, date and pla opinion, death oc	ce, and due to the cau curred at the time, date	se(s) and manner as s e and place, and due to	ated. the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier			29c. Licens	se number	290	d. Date signed (Month,	Day, Year)
	14		1/// /XXIII	1/1			D08754		ecember 28	, 2004
	17		30. Name and address of person who of Thomas A Bensinge				r Dr., #	205 Greenb	elt. Marvl	and 20770
	Sta Registr		31. Date filed (Month, Day, Year) DEC 28 200	32. Registrar's Signat	ure &	Spork			<i></i>	20110

			St. State Registrar AMEND FTEM#10a		artment of Health and I ntificate of Reath		ne 2004	42690
	Physicia		Decedent's Name (First, Middle, Last) MINA	SORKIN		2. Date of Death Month DECEMBER	Day 2004	3. Time of Death 7:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or Location of Death		4c. County of Death	
	LAGITIII	٠,	BRIGHTON GARDENS		ROCKVILLE		MONTGOME	RY
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Y	9. Birthr	place (State or Foreign
	Director		065-26-0071 1□M	² 75 Yrs.	Months Days Hours Min.	JULY 24,	1929 NEW	YORK
	p ,		Usual Residence of Decedent	10c. City, Town or Lo	and in a			10d. Inside City Limits
	anyla ehov	_	FIORIDA HARYLAND 10b. County PALM BEACH MONTGOMERY		DOGA DAMON			1XX es €₩No
	he M	Director		CHEVY C	HASE BOCA RATON	100	. Citizen of What Cour	Λ
	with t	吉	19658 DINNER 1 5555 FRIENDSHIP BLVD	KEY DRIVE		1500		
	be filed within 72 hours after death with the Maryland tall Hyglene. Id other than "netural", or Items 23a or 28e-f ehow avant. I'm Medical Exertified in trivial be notified at	Funeral			20815 33498-		UNITED STA 14. Race - Americ	
_	ter d	Ë	1 Never Married 21√ Married 1	TYes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White,	
2	urs al	þ	3 ☐ Widowed 4 ☐ Divorced Y	Yes, Give ear or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	HITE
9500-612	2 ho	ted	15. Decedent's Education		dent's Usual Occupation kind of work done during most of wor	16	b. Kind of Business/In	dustry
7	hin 7	ple	(Specify only highest grade com Elementary/Secondary (0-12)	oliege (1-4or 5+)	DO NOT use retired)	King		
	er th	Completed			LAWYER		LAW	
<u> </u>	9 = 0 %	Be (17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma		
Maryland 2	es 1 and 2 should be of Health and Mental of Ham 27 is marked or other traumatic av	ပ္	HARVEY FI	LAX		NNAH	MENDELSOH	
ם	2 sho and Is m		19a. Informant's Name/Relationship (Type, F		ng Address (Street and Number or Au			Code)
2	and ealth m 27		MARSHALL SONENSHINE,		LANE, SCARSDALE,			
0	Pages 1 nent of H int: If Ita		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Pemor	at from State	matory or other place)		c. Location - City or To	own, State
altimore,	men tant: jury		'4 □ Donation 5 □ Other (Specify)		AEL CEMETERY 12/2			NEW JERSEY
Ra	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service Livensee	<u> </u>	2. Name and Address of Facility ANZANSKY-GOLDBERG 170 ROCKVILLE PIK	MEMORIAL E, ROCKVI	CHAPELS, LLE, MD 2	INC. 0852
			23a. Part Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the death. Do not enuse on each line.	ter the mode of dying, such as cardiac	or respiratory arrest		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	CEREBRAL VASCULAR	ACCIDENT			Onset and Death 8 MONTHS
	/Medical		resulting in death)	Due to (or as a consequence of):				
	Examiner		Sequentially list conditions, b.					
	p ti	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequence of):				
	and and I-tran	хап	that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
8/60,	death certificate be executed eattending physician and of for use as the burial-transit	E		ous to (or us a someoquentee or).				
	physic the	dlcal	d					
× O	death certifica attending pl	Physician/Me	IF FEMALE: 23c. If	yes, outcome of pregnancy			23d. Date of delive	an.
XOX	atten for u	cian	in the past 12 months?	Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		Month	Day Year
j	the d	ysic		Unknown	3 01101 (00001))			
J.	The law requires that the de ite has been signed by the a bage 2 should be detached f		Part II. Other significant conditions contribu	ting to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
ds,	uires sign d be	d by	CACHEXIA			1 ☐ Yes	2□No 3□Prob	oably 4 Unknown
Ö	w require been si should b	Completed				24a. Was an	24b. Were auto	opsy findings available
Vital Record	has ge 2	E D				autopsy performe	d? prior to co	mpletion of cause of
g			25. Was case referred to medical		OR Bloom of Day	1 ☐ Yes 2 ☐	No 1 ☐ Yes	2 L No
	nyaician: The la nis certificate ha: I director, page 2	o Be	examiner? 1 Yes 2 No	tal: 1 ☐ Inpatient 2 ☐ ER/Outpatie			e 6V Other (Special	ASST. LIVIN
Ö	Attending Phyaician: r death. ector: After this certific by the funeral director;	To It	27. Manner of Death 28	Ba. Date of Injury 28b. Time of	of 28c Injury at	28d. Describe how		2051. LIVIN
0	nding Phy th. : After thi s funeral o	tlor	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
DIVISION OF	or Attendii after death. Director: A in by the fu	ifica	3 Suicide 6 Could not be	e. Place of Injury - At home, farm, st	reet, factory, office		et and Number or Rura	al Route Number,
S		Certification:	4 Homicide determined	building, etc. (Specify)		City or Town,	siate)	
	To the Hospitel or within 24 hours after To the Funeral Director completely filled in the formula of the formul		29a. Certifier 1 Certifying Physicia	n: To the best of my knowledge, deal	th occurred at the time, date and place	, and due to the caus	se(s) and manner as s	tated.
	n 24 n 24 ne Fu	edical		On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occu	irred at the time, date	and place, and due to	o the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier		29c. License number	29d	. Date signed (Month,	Day, Year)
	20		1. heile be	med MP	D0013187	D	ECEMBER 24	, 2004
	W		30. Name and address of person who comple		, Print)			
			J. NÉILL KENNEDY, M.			CHEVY CHAS	SE, MD 20	815
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Sportsi			
	Registi	al	DEC 28 2004	No. of the last of	//			

DHMH 17 Rev 1/2001

			1 - For State Registrar	tate of Ma	ryland		rtment <i>tificate</i>			ınd M		giene Reg. Nd:-	001	ļ.	421	592
	Dhusiai	22	Decedent's Name (First, Middle, Last)						-		2. Date of Dea	ath Day	Yee	A.F.	3. Time o	f Death
	Physici /Medic		Vartanoosh	Sayad	ian						Decemb				4:25	P M
	Examin	er	4a. Facility Name (If not institution, give stre	et and number)					Location o	f Death			ounty of De			
			Suburban Hospital	7 4-0	//	and the same of a column	Bet If Under	hes		04 Hro	0.5		ontgo			
	Funeral Director		210-23-0203	2 [X] F 7. Age	85	ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da Jan 22	y, Year) 191	.9 Ri	Countr	ice (State y) La	or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	cation							10	d. Inside C	city Limits
	Mary -f sh	ğ	Maryland Montgomer	X7	Roc	kville	,								1 ⊋ Yes	2 □ No
	r 28a	by Funeral Director	10e. Street and Number	<i>J</i>	noc	KVIIIC	10f. Zip	Code				10g. Citize	n of What	Countr	y?	
	th wit	alD	199 Rollins Avenue,	#547			2	2085	2			Uni	ted S	tat	es	
	ams ams	ner	11. Marital Status 12.	Was Decedent Ev Armed Forces?	ver in U.S	3. 13. V	Vas Decede	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	- 14	. Race - Al Black, W			
36	or It	J.	1 Never Married 2 Married	1 ∐ Yes 2∭ No If Yes, Give	0		☐ Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,	110411, 010.7		pecify:	riite, ei	.c.	
Ö	hours tural		3 \ Widowed 4 □ Divorced	Year or Dates:					dian				V	Vhi:		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show the Medical Examena must be multied at	Completed	15. Decedent's Educati (Specify only highest grade co	mpleted)		16a. Deced (Give I life. D	ent's Usual kind of worl OO NOT use	k done a	lurina most	of working	ng	16b. Kind	of Busines	ss/Indu	istry	
712	iene.	Ë	Elementary/Secondary (0-12) ·12	College (1-4or 5+	-)	Mani	curis	st				Веа	auty (Car	e	
פ	e filec of Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden S	umame)			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than *natural; or Items 23a or 28a-f show among injury or other traumatic svent, the Medical Examinat must be notified at once.	ToE	Bagrad Hakobian							riam			adian			
Mar	12 sh h and 7 is rr rraum		19a. Informant's Name/Relationship (Type,	•			_				Route Numbe				ode)	
	1 and Health em 2 ther t		Leon Sayadian, Son 20a. Method of Disposition		20b. Pla						kville,		2085 tion - City		n State	
nor	O S E		1 ☐ Burial 2 X Cremation 3 X Rem	oval from State		metery, crem			1							
Baltimore,	artme ortan injury		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Piner Service Licensee		Nat	ional					/2004					ginia
Ba	Dep Imp		Hary to	fra:			/U RC	CKV.	TITE .	rike	Memoria , Rockv	ттте	apels MD :	, I ₁ 208	nc. 52	
П			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated to the complete shock of the complete	ons that caused to ause on each line	he death.	Do not ente	er the mode	of dying	g, such as o	cardiac o	r respiratory ar	rest,		1.	Approximat nterval Bet	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	PULMONAR	Y_AL	VEOLAR	THRO	мво	SIS						Onset and DAY	
	/Medical Examiner			Due to (or as a			IC TON							1	77 T A D	
		e.	Sequentially list conditions D. —	PULMONAR Due to (or as a			STON							1	YEAR	-
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			•										
ó	exec an an rial-tr	Еха	resulting in death) Last	Due to (or as a	conseque	ence of):								1		
8760,	death certificate be executed e attending physician and ad for use as the burial-transit	dical	L d													
9	e as t	Med	IF FEMALE:											1		
Вох	eath certific attending p	lan/	23b. Was decedent pregnant un the past 12 months?	If yes, outcome of 1□Live birth 2	Fetal	death 3 🗌	Ectopic pre					23	d. Date of d Month			Year
o.	that the de led by the a detached t	Physiclan/Me		4□Pregnant at ti 9□ Unknown	me or dea	atn 5⊔	Other (spe	crty)							,	
<u>а</u>	that led by deta	y Ph	Part II. Other significant conditions contrib	uting to death but	not result	ting in the un	dertying ca	use give	n in Part I.		23e. Did to	bacco use	contribute	to the	cause of c	death?
Records,	The law requires that the site has been signed by the bage 2 should be detached.	ed by	CORONARY ARTERY	DISEASE							1□Y	es 2X	No 3 🗆	Probab	oiy 4 ⊡l	Jnknown
000	law requir as been si 2 should I	Completed									24a. Was a		24b. Were	autops	y findings	available
æ	The lav	E o									autop: perfor 1 Yes	med?	prior to death' 1 □ Ye	?	itetion of c	ause of
Vital	ysician: Th is certificate director, paç	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or	A				
Ž	S S S	To	1 ☐ Yes 2 🔀 No Hosp	ital: 1 X Inpatient	t 2□E	R/Outpatient	3 🗆 DOA	Othe	r: 4 🗆 Nur	sing Hor	ne 5 🗆 Resid	ence 6 [Other (Sp	ecify)		
Ē	ing Ph		27. Manner of Death 1 △Natural 5 ☐ Pending	8a. Date of Injury (Month, Day	Year) 2	28b. Time of Injury		c. Injury Work			8d. Describe h	ow injury o	occurred			
<u>s</u>	ttend death stor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be	0- 01(1-'	444		М		′es 2□N		06 1	M	, ,			
Division of	after after d in by	Certification:	4 Homicide determined	8e. Place of Injury building, etc.	(Specify)	ne, tarm, stre	et, factory,	office		2	8f. Location (S City or Tow		Number or I	Hurai F	loute Num	ber,
	ospite hours uneral		29a. Certifier (Check only 2 Medical Examiner:	in: To the best of	my know	rledge, death	occurred a	t the time	e, date and	place, a	nd due to the c	ause(s) ar	id manner	as stat	ed.	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	one)	and manner state	ed.	on and or my		License					signed (Moi			
)	E. Z E. 8		29b. Signature and title of certifier.	LYV9												
	\mathcal{V}	-	30. Name and address of person who compl	_	ath (Item 2	23a) (Type. F		0536	012			DECEM	IBER 2	ι,	2004	-
			ARUNA S. NATHAN, M.				,	E, F	ROCKV	ILLE.	, MD 2	0852				
	Sta	. 9	31. Date filed (Month, Day, Year)	32. Registrar	's Signatu			uks								
	Registr	ar	DEC 28 2004	Mark	THE STATE OF THE S	1	Med	4740								

State of Maryland / Department of Health and Mental Hygiene 42693 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 200^{Yea} DECEMBER 19 1:25PM M FRANCES G. TRACEY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner QUEEN ANNE'S CORSICA HILLS-GENESIS ELDERCARE CENTREVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV 30 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 24□ F MARYLAND 218-07-0464 86 Yrs Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f show the Medical Examiner must be notified at EASTON TALBOT Director MD 1 √ Yes 2 □ No 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 1020 N. WASHINGTON ST. #904 21601 USA death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE ⋛ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Al Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC SCHOOL SECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) rmit. Pages 1 and 2 should be fili partment of Health and Mental Hy portant: If Item 27 is marked off y injury or other traumatic even HOWARD GANNON LIDA DILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31160 HUTEMANN ALLEY, CORDOVA, MD 21625 MARY ANN DULIN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State JOSEPH'S CEMETERY 12-22-2004 CORDOVA, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA permit.
Departr
Importa
any inju 21. Signature of Funeral Service Licenses K. MERCEROA 200 S. HARRISON ST EASTON, MD 21601 JOH 2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Nephroeleons **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): the attending physician thed for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 → Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 **□**⊀\0 within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No 1 Inpatient ၉ 2 EP/Outpatient 3 DOA wrsing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 32036 hale, MD 2/6/9 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe 2108 D. Don () C00) 31. Date filed (Month, Day, 32. Registrar's Signature Year State Registrar

			1 - For State Registrar			d / Depa		lealth and	Mental Hyg	iene g. No.2	004	42694
1	Physic		Decedent's Name (First, Middle, Las BEN	t)		TO	BIN		2. Date of Dear Month Decembe		. 2004	3. Time of Death 8:25P. M
	/Medi Examir		4a. Facility Name (If not institution, give Ring House	street and number)			4b. City, Town, o	r Location of Deat Lle		4c. Cc	ounty of Death	1
	Funeral Director		5. Social Security Number 6. Security Number 100–09–0705 Usual Residence of Decedent	x 7. Ag		ast birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day) March29	Year)		lace (State or Foreign try) York
	Maryland a-f show	tor	10a. State 10b. County Maryland Montgome	ery	10c. City	r, Town or Lo	ckville				1	0d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 28	Funeral Director	10e. Street and Number 1801 E. Jefferson	STreet,	#231		10f. Zip Code 20	852	1	-	of What Coun	•
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28a-f show eny injury or other traumatic avent. The Medical Exercime must be notified at an once.	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)		Race - Americ Black, White, o	
21215-0036	vithin 72 ho ne. han "natu e Medical	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5	5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired al Techni	during most of wo i)	rking		of Business/Inc	dustry
land 2	ild be fited w ental Hygie ked other t ic avent, th	To Be Col	12 17. Father's Name (First, Middle, Last) Joseph	1-4 Tob	oin	Delic	ar recini		ne (First, Middle, I	Maiden Su	istry mame) enberg	
Ž	and 2 should baith and Men n 27 is marke ler traumatic.		19a. Informant's Name/Relationship (7) Jane Rosov –Daught			1	-		ethesda,	-		•
a)	Pages 1 and ment of He ant: If Itam		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □		Cé	emetery, crer	sition (Name of matory or other place Morial Ga	rdens 12	Date 2/28/2004		tion - City or To	
Balt	permit. Departe Importe eny inj		21. Signature of Funeral Service Licen: Denold V. B.	gward		D 4.	Name and Address Onald V. 400 Povide	ss of Facility Borgward r Mill R	lt Funera Coad Belt	l Hom svill	e, P.A. e, Mary	land 20705
	Pnysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or come shock, or heart failure. List only a limit of the cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		tive a consequ Fibr	Heart Jence of): rillat:	Failure	g, such as cardia	c or respiratory arm	est,		Approximate Interval Between Onset and Death
<u></u>	death certilicate be executed e attending physician and id for use as the burial-transit	ical	IF FEMALE:	d. 23c. If yes, outcome						230	I. Date of delive	2/
.O. Box	at the death by the atten tached for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)			230		Day Year
Records, P.	The faw requires that the site has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions co Vascular Dementia		ut not resu	Ifting in the u	nderlying cause giv	en in Part I.		oacco use		e cause of death?
		Completed							24a. Was a autops perform	V	prior to con death?	osy findings available inpletion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		ath (Check only on			
o	After	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatie 28a. Date of Inju (Month, Da		ER/Outpatien 28b. Time of Injury	28c. Injur Wor	/ at	lome 5 Reside 28d. Describe ho)
Division	D it to	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At ho c. (Specify	me, farm, str	eet, factory, office		28f. Location (St. City or Town	reet and N , State)	lumber or Rural	Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dirac completely filled in the Funeral Di	edical	29a. Certifier (Check only one) 1 Certifying Phyone) 2 Medical Example 1	ysician: To the best iner: On the basis of and manner sta	of my knov f examinat ated.	wledge, death ion and/or in	n occurred at the tirvestigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	iuse(s) an ate and pla	d manner as sta ace, and due to	ated. the cause(s)
)	vithin A Comp	W	29b. Signature and title of certifier	~//e			29c. Licens	7784	25		igned (Month, E mber 27	
	15		30. Name and address of person who con Damien Doyle, M.D.					ckville,	Maryland	2085	52	
	Sta Registi		31. Date filed (Month, Day, Year) DEC 28 2004	32. Registr	ar's Signat		Sporks	•				

			1 _ For		of Maryland / Dep	partment of Health are ertificate of Death	•	ygiene	
			Registrar 1. Decedent's Name (First, Middle	o, Last)			2. Date of D		3. Time of Death
	Physic /Medi		Walter	H	Thon	nas	Dec	25 2001	
	Exami		4a. Facility Name (If not institution	, give street and nu	mber)	4b. City, Town, or Location of [4c. County of De	
			Riderwood Villa	ge		Silver Spring If Under 1 Year If Under 24		Montgo	merv
п	Funeral		5. Social Security Number	6. Sex 1⊠M 2□F	7. Age (In yrs. last birthday	Months Days Hours	Min. (Mo <i>nth</i> , D	irth 9. B lay, Year) (irthplace (State or Foreign Country)
	Director		451-34-9596 Usual Residence of Decedent		90 ""		Mar. l	l3, 1914 Vi	rginia
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examin or matter rediffed at		10a. State 10b. County		10c. City, Town or L	ocation			10d. Inside City Limits
	Ba-1 s	Director	Maryland Montg	omery	Silver	Spring			1 ☐ Yes 2 ₺ No
	with th	Die	10e. Street and Number	-		10f. Zip Code		10g. Citizen of What (Country?
	eath v	Funeral	3160 Gracefield			20916	0.407. 14	U.S.A.	
(0	fter d	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed Fo	rces?	. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	uerto Rican, etc.)	Black, Wh	nerican Indian, nite, etc.
936	ours a	b	3 🛣 Widowed 4 □ Divorced	If Yes Giv	ve Viet Nam	1 ☐ Yes 2 ☑ No Specify:		Specify:	hite
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121	within lene. than "	mpl	Elementary/Secondary (0-12)	College (1	life.	DO NOT use retired)	g		
d 2	be filed within 72 hours after death with the Marylar Ital Hygiene. 4d other than "natural", or Itams 23a or 28a-f show of other than "natural", or Itams 22a or 28a-f show event. The Medical Exams activities to the Medical Exams with the Medical Exams		12th 17. Father's Name (First, Middle, I	Last)	Owne:		Name (First, Middle	Auto Serv	ice Station
lan	Mental Marked o	To Be	James	W.	Thomas	Nina	(* 1104)	Alice	Brammer
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M	-	19a. Informant's Name/Relationsh			ing Address (Street and Number of	r Rural Route Numb		
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Baltimore,	S to = 10		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place)	Date	20c. Location - City o	r Town, State
Ħ.	permit. Pag Department Important: I any injury o		' 4 □Donation 5 □ Other (Sc	gecify)	Sycamore	Ba. Cemetery 12	/30/2004	Stuart, Vi	rginia
Bal	permi Depar Impo any ir		21. Signature of Funeral Service	idensee		22. Name and Address of Facility			
			23a. Part1. Enter the disease, or	complications that c		1800 New Hampshi			Approximate
	Physician		Immediate Cause (Final	0		nter the mode of dying, such as car	ala or respiratory a		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		(or as a consequence of):	na			3 days
h	Examiner		Cognostially list conditions	b. Co	ronaru	goteru o	tisease		
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	ecute and I-trans	Examiner	that initiated events resulting in death) Last	C. Due to	(or as a consequence of):				
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Вох	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy	75		23d. Date of de	alivery
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	o the Hospital or A thin 24 hours after the Funeral Dire mpletely filled in b	O	29a. Certifier 1 Certifying	Physician: To the	hest of my knowledge, don't	th occurred at the time, date and pl			
	e Fur	edical	(Check only 2 Medical E	xaminer: On the ba	asis of examination and/or in	en occurred at the time, date and provestigation, in my opinion, death o	ccurred at the time,	date and place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	11		29c. License number		29d. Date signed (Moni	th, Day, Year)
)	10		Loveen 1	uthum	and MD	D 59524		Dec 27.	2004
	U		30. Name and address of person w	ho completed caus	e of death (Item 23a) (Type,	Print)	n (00 · · · ·	C AAN 0-	200
			LOVEEN J. PUTHU 31. Date filed (Month, Day, Year)	INNNH 3	egistrar's Signature		KOKKINE	9, IVIV 200	1014
	Sta Registr		DEC 28 2		years B	Sparke			

DHMH 17 Rev 1/2001

		_	For State Registrar		aryland / Depa	artment of H		Re	g. No 2004	42697
	Physicia /Medic	al .	Decedent's Name (First, Middle, Last, William Edward Will As. Facility Name (If not institution, give	еу		Ah City Town or	Location of Death	2. Date of Death Month December	Day Year	3. Time of Death 10:45 arm
	Examin Funeral Director	er	Reeders Memorial F 5. Social Security Number 6. Sec	lome	o (In yrs. last birthday) 90 Yrs.	,	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Washingto	thplace (State or Foreign
	D D		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo			Aug. 12	, 1914 Mar	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
E	with the M 3a or 28a-f	I Director	Maryland Washingto 10e. Street and Number 210 South Artizan	on	Williamsp	10f. Zip Code 21795		i	og. Citizen of What Co	
5-0036	72 hours after death with the Maryland natural; or Itame 23a or 28a-f show Jical Examinat nast be notified at	by Funeral		12. Was Decedent E Amed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	lo	Was Decedent of Hi If Yes, specify Cuba			14. Race - Ame Black, Whit	
2121	be filed within 72 hours after death with the Marylan ital Hygiene. Indicate then "natural", or Itame 23a or 28a-f show event, the Medical Exercites must be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation e completed) College (1-4or 5	+) (Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of work	ing P	ipe Organ	_{Andustry} Manufacturer
Wile Maryland	should be fit and Mertal H is marked oth umatic even	To Be	17. Father's Name (First, Middle, Last) John Edward Wiley 19a, Informant's Name/Relationship (Ty	rpe. Print)	19b. Maili	ng Address (Street a	18. Mother's Nam Beulah E and Number or Rur	. Moudy	Maiden Surname) City or Town, State, .	Zip Code)
	s 1 and 2 should f Health and Me item 27 is marke other traumatic		Trudy Decker (Dau 20a. Method of Disposition	ighter)		alvert Te	errace Ha	gerstown	, Maryland	21742
ame. Baltimore,	permit. Page Department Important: It any injury or once.		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Indones		Greenlaw	n Mem. Pa	rk Jan.3			rt, Maryland ococheague
	Physician		23a. Paft1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final	ne cause on each lin	the death. Do not en	ter the mode of dyin	g, such as cardiac	Mary land or respiratory arre	21795 est,	Approximate Interval Between Onset and Death
	/Medical Examiner	ner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	Due to (or as a Due to (or a) Due	a consequence of): http://www.consequence.of): a consequence of):	ndiomyo	pathy			years.
8760,	te be ysicia ne bur	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):	nells fus				years
P.O. Box 6	the death certifica y the attending ph sched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other <i>(specity)</i>			23d. Date of de Month	livery Day Year
	w requires that the de been signed by the s should be detached t	by	Part II. Other significant conditions con	ntributing to death bu	ut not resulting in the u	nderlying cause give	en in Part I.		acco use contribute to	o the cause of death? robably 4 XUnknown
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Divisio	ospitaf or Attending hours after death. uneral Director: Aftei ly filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ury - At home, farm, st c. (Specify)		Yes 2□No	28f. Location (Str City or Town	reet and Number or Ri , State)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical ((Check only 2 Medical Exami	sicien: To the best oner: On the basis of and manner sta	ol my knowledge, deat examination and/or in ited.	vestigation, in my or	pinion, death occur	red at the time, da	ate and place, and due	o to the cause(s)
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54	3 Sta	te	30. Name and address of person who compressed to the series of person who compressed to the series of the series o	311 Lappar	eath (Item 23a) (Type, IS Rd.Boons ar's Signature		21713 30	1-432-84	70	
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12 4UD 12 WARREN 25 2000 LATHE EIN L /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MUNTGOMERY RNOR MKUMA 1000 mac ADVINIT CU ASTURON If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months 1 ☐ M 2 💢 F 87 Maryland Director 577-20-1236 Usual Residence of Decedent Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County or 28a-f show Examiner toust be notified at ¥GYes 2 □ No D.C. N/A Washington Director lhe ! 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code #202 U.S.A. 2125-4th Street, N.W. 20060 Itams 23a death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene introducent: If item 27 is marked other than "natural", or its any injury or other traumatic event, the Madical Examina 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: Black 21215-0036 1 ☐ Yes XXNo Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Domestic 8th 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Frank Warren Mamie Marshall 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Estella Tinker/Niece 5710 East West Hwy., Riverdale, Md. 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Bunal 2 Cremation 3 Removel from State
4 Donetion 5 Other (Specify) Fort Lincoln Cem. 12/30/04 Brentwood, Md. 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc. 21. Signature of Funeral Service Licenses Nac 814- Upshur Street, N.W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SE751S Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner repherel VAICULAR 31282161 PATRICURIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 9SN 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Year jo Month Day 5 Other (specify) should be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Winknown .21 OUT GANGRUNT Ammonow Be Completed been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page 2 certificate 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) director. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 R/Outpatient 3□ DOA Certification: To this 27. Mann f Death 28c. Injury at Work? in by the funeral 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Dire 4 Homicide Hospital 1 crifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifies Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 12-25- 200 3542 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 and MXCMA Nenc 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 28 2004 oukal Registrar DEC

			For State Registrar	State of	Marylan	d / Depa	artment of H	lealth a Death	and Ment		ene ()	04	426	99
	Dhuaiai		1. Decedent's Name (First, Middle,	,					2. D	ate of Death	1	Year	3. Time o	f Death
	Physicia /Medic		Helen Curtin	Wallace						onth cember		2004	11:20) A ^M
	Examin	er	4a. Facility Name (If not institution, Wilson Health Ca	-			4b. City, Town, o		of Death		4c. County	•		
	Funeral				. Age (In yrs.	last birthday)	Gaither:		24 Hrs. 8. Da	ate of Birth	Montg		place (State o	or Foreian
Н	Director		578-62-1189	1□M 2X0F	96	Yrs.	Months Days	Hours	Min. Mai	ate of Birth Month, Day, r . 11,	1908	MA Cou	ntry)	
	pu 🔪		Usual Residence of Decedent 10a. State 10b. County		100 Cit	y, Town or Lo	antion						104 (Sec. 1 Co. 20
	Aaryla f ehor	ō	Md. Montgo	omery		thersb.							10d. Inside C 1X\text{Yes}	2 □ No
	28a-	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cour	ntry?	
	h with	i Di	401 Russell Ave	e. Apt.#	508		2087	7			nited		•	
	ams 2	Funerai	11. Marital Status	12. Was Deced	ent Ever in U.	.S. 13.	Was Decedent of H	lispanic Orig	gin? (Specify Y	res or No-		ce - Americ	can Indian,	
36	or It	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 If Yes, Give	. No		1 ☐ Yes 2X No	Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,, 0.0.,	Specif		nite	
Ö	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f ehow the Madical Exam har must be notified at	ed b	15. Decedent's	Year or Dat	es: 	16a Dece	dent's Usual Occup	ation		1	6b. Kind of B			
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Ma	id 2 sl Ith an 27 le r traur		Michael A. Wall				ng Address <i>(Street:</i> ke Court		ville,		•	State, Zip	Code)	
ē,	t Hea t Hea item		20a. Method of Disposition		_	lace of Dispo	sition (Name of natory or other place		Date	2	Oc. Location	- City or To	own, State	
Ë	Page nent o int: If		1 ☐ Burial 2 🂢 Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe		ate		itan Crem		Dec. 31 2004	L, A	1exand	lria,	Va.	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any high or other traumatic event, the Medical Exament interfere colline of once.		21. Signature of Funeral Service Li	ense Dula			Name and Addres	_			eral H		Id. 208	377
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications pat cal	used the deat							-8,	Approximat Interval Bet	te
	Pnysician		Immediate Cause (Final disease or condition	my one carge on ea	netar	L	Come	a					Onset and	Death
	/Medical Examiner		resulting in death)	Due to (o	r as a conseq		(J) (L	C4					10.0011	20
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Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		th 2 ☐ Feta	Ideath 3	Ectopic pregnancy					ate of delive		Year
o.	that the death ed by the atte detached for	ysic	1 Yes 2 No	4∐Pregna 9∏Unknov	nt at time of d vn	eath 5∟	Other (specify)						,	
Δ.	The law requires that the tee has been signed by thoage 2 should be detached.	y Ph	Part II. Other significant condition	s contributing to dea	th but not res	ulting in the u	nderlying cause give	en in Part I.	2	23e. Did toba	acco use con	tribute to th	he cause of d	leath?
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Œ		Com								perform	ed?	death?	2 □ No	1036 OI
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of	문 モニ	٥ -	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ In		ER/Outpatien 28b. Time of		anut nut	rsing Home 5		nce 6 Oth		y)	
On	Attending ir death. actor: After by the funer	tion	1. Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month	Day Year)	Injury	Worl			703011 <u>0</u> 0 1101	v injury occur	100		
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ō	ital or rs afte al Dir led in	Cert	- Indinicide	Dullung	g, etc. (Specify	Y) 				ny or rown,	State)			
	To tha Hospital or Attending I within 24 hours after death. To tha Funaral Diractor: After completely filled in by the tuner	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the b xaminer: On the bas and manne	is of examina	wledge, death tion and/or inv	n occurred at the tin restigation, in my of	ne, date and pinion, deat	d place, and du h occurred at t	ue to the cau the time, dat	use(s) and ma te and place,	anner as st and due to	tated. the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	1 1 -	0 5		29c. License	e number		-	d. Date signe			
	12		Atu K 1	Milma	le m	7	D19	729	4		Decen	they i	21,20	04
	•		30. Name a address of person w	ho completed cause			Print)	1-1	lud un	0.	Decen d. 20	000		
	Sta	te.	31. Date filed (Month, Day, Year)	enich 32. Be	jistrar's Signa	ture	100-	100 /l	mrs my	c, M	d. 20	17		
	Registr		DFC 282	004	gistrar's Signa	B	ppour							

Funeral

Director

10c. City, Town or Location Maryland Prince George 7 is marked other than "naturat", or Items 23a or 28a-f shov treumatic event, the Medical Examiner must be notified at Completed by Funeral Director Marylasnd Prince Georges College Park 10e. Street and Number 10f. Zip Code with 9306 St. Andrews Place 20740 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No. If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 5-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1943-1945 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Maryland 2121 l Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Systems Analyst 17. Father's Name (First, Middle, Last) 12 should be fit h and Mental H Be William Snowden Arnold Ethel 2 Adams 19a. Informant's Name/Relationship (Type, Print) Item 27 Linda L. DiGiovanna/daughter other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ō 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department o Importent: If a = 5 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 12/28/04 Signature of Euneral Service Licensee 22. Name and Address of Pacility
Holloway Funeral Home Profer
501 Snow Hill Rd. Salisbury
23a. Part. Enter the disease, or compilations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician SEPTIC SHOCK /Medical Due to (or as a consequence of). Examiner OXIC MEGA COLON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Be Completed by Physician/Medical Examiner burial-transit SEUDOMEMORANEOUS Due to (or as a consequence of) Box 68760. NEUMONIA IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4□ Pregnant at time of death P.O. 9□ Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 24a. Was an 1 ☐ Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: Division or Attending 5 Pending investigation 1 Natural s after decel Director: Attended by the fire 1 Yes 2 No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier Medical (Check only one) completely and manner stated within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 145 E. CARROLL 5A453424 DUDAS 31. Date filed (Month, Day, Year)
DEC 2 9 2004 32. Registrar's Signature State Registrar

1- State Registrar Amended 12-29-04 item #'s 10 Refifficate of Death map Reg. No. UU4 2. Date of Death Decedent's Name (First, Middle, Last) Month Dav **Physician** 2239 Dacember 27, 2004 William Howard Arnold /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** NICOMICO REGIONAL MEDICAL 54/156414 FENINSULA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9/21/1918 6. Sex Birthplace (State or Foreign Country) 1 2 □ F Months Days Hours 237-18-2472 86 NorthCarolina Usual Residence of Decedent 10d. Inside City Limits 1 XYes 2 □ No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31679 Dagsboro Rd., Parsonsburg, MD 21849 20c. Location - City or Town, State Salisbury, MD 22. Name and Address of Facility
HOlloway Funeral Home Professional Association
1 501 Snow Hill Rd. Salisbury MD 21804
Approximate Approximate Interval Between Onset and Death ENTERO COLITIS 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- For State of Maryland	I / Department of Health and M Certificate of Death	lental Hygiei		2701
	Dhysisi		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Dav Year	3. Time of Death
	Physici /Medic		Mabel Alder		Dec.27,2	004	1930 ^M
	Examin	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Shady Grove Adventist Hosp 5. Social Security Number 6. Sex 7. Age (In yrs. Ia		S Bata of Birth	Montgome	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>ln yrs. la</i> 217-07-0626 1 M 2 X	Vrs Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 4,1	ar) 9. Birthplac Country)	e (State or Foreign
			Usual Residence of Decedent		Aug. 4,1	917 Mary	<u> rand</u>
	Maryiano	tor	Md. 10b. County 10c. City, Montgomery	Town or Location Rockville		10d.	Inside City Limits 1 X Yes 2 □ No
	or 28.	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country	?
	ath w	ral	9805- Veirs Dr.,	20850		USA	
36	filed within 72 hours atter death with the Maryland Hyglene. ther then "natural", or Items 23a or 28e-f show int, Ira Madical Examinat must be notified a	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spull of Yes, specify Cuban, Mexican, Puerlo 1 Yes X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Black, White, etc. Specify: Wh:	
9	tura atura	edit	15. Decedent's Education	16a. Decedent's Usual Occupation	16b	. Kind of Business/Indus	try
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P		Bec	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
<u>ylaı</u>		To	Harvey M. Gross	Isabell	la Yocum		
, Maryland 21215-0036	d 2 shand thand 7 is m		19a. Informant's Name/Relationship (Type, Print) Doris Gross-Sister-In-Law	19b. Mailing Address (Street and Number or Rura 9509- Veirs Dr., F			,
Baltimore,	of of the state of		20a. Method of Disposition 1 Superior State 20b. Pla 2	nce of Disposition (Name of majay, crematory or other place) odlawn Cemetery 12/3	20c. 30/04 Ba	Location - City or Town, altimore, N	, State Md .
Balt	permit. Pag Department Importent: I any injury o once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Hysong Co., Inc	C.	DG	
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Ar Ini	oproximate terval Between
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	/Medical		resulting in death) Due to or as a constitute	ance of):		,	1
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182	physic the	dicat	d				
9 x	ath certific titlending p or use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnan	су		23d. Date of delivery	
О. Вох	90 90	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	death 3 Ectopic pregnancy		Month Da	y Year
Vital Records, P.	signed d be de	by	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the c	eause of death?
Ö	law requas been 2 shoul	Completed			24a. Was an	24b. Were autopsy	findings available
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>	Physician: rthis certific ral director,	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 E	R/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Residence	6 ☐Other (Specify)	
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Division	spital or Attending ours after death. nerel Director: After filled in by the fune	Certification:	A CONTRACTOR OF THE PROPERTY O	ne, farm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Ro ate)	oute Number,
_	Hospita 4 hours Funerel ely fillec	Medical Co	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.				
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of cartifier	29c. License number	29d.	Date signed (Month, Day	v, Year)
	- 510		Demen trumben MD	24971	1	ecember 29,	2004
R	(20)		30. Name and address of person who completed cause of death (Item)				V 1
	(20)		1522 E STARRY Conve Rd.	Rockielle mo			
	Sta		31. Date filed (Month, Day, Year) . Registrar's Signatu	ire			
	Registr	ar	DEC 3 0 2004	Coole			

			1 - For State Registrar		ryland / Depa <i>Ce</i>	artment of H	lealth and M Death	ental Hygie	ene2004	42702
I	Physic /Medi	cal	1. Decedent's Name (First, Middle, La Vernon Reginald	Alford		T		2. Date of Death Month December	^{Day} 2004	3. Time of Death 1:12 A M
	Examir	ier	4a. Facility Name (If not institution, given Fort Washington 5. Social Security Number 6.3	Hospital	The way to at hinth days	4b. City, Town, or Fort Was	shington If Under 24 Hrs.		4c. County of Death Prince Geog	
	Funeral Director		577-02-3057 Usual Residence of Decedent	TH ODE	(In yrs. last birthday) 43 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye May 22,	ear) 9. Birthp Cour 1961 Wash	lace (State or Foreign http) Lngton, DC
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Iteme 23a or 28a-f show eumatic event, the Medical Evarting must be notified at	Funeral Director	D · C · N/A		Washingto			100	1 Citizen of What Cour	0d. Inside City Limits 1 Yes 2 No
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936	urs after dea st', or Iteme	by Funer	11. Marital Status 1 □XNever Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:		14. Race - Americ Black, White, Specify: Blac	an Indian, etc.
1215-0	within 72 hounders.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation	16a. Deced (Give life.		ation during most of workir d)	ng	o. Kind of Business/Ind	dustry
Maryland 21215-0036	uld be filed v Aental Hygie rked other I tic event, to	0	17. Father's Name (First, Middle, Last, Stanley Alford)	Sti	ıdent	18. Mother's Name Arlene Do	(First, Middle, Mai	ducation	
, Mary	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 le marked, any niury or other treumatic events.		19a. Informant's Name/Relationship (Arlene Alford /		4109	13th St.	N.E., Was		ity or Town, State, Zip	
Baltimore,	Pages 1 lent of Ho nt: If iter		20a. Method of Disposition 1		20b. Place of Dispo cemetery, cren		ery 12/31		Location - City or To	
Balti	permit. Departm Importe any nju		21. Signature of Funeral Service Licer	e free	74	Name and Addres	ss of Facility McGu ia Ave. N	uire Fune .W., Wash	shington, ral Servic . D.C. 20	012
п	Physician / Medical Examiner but site private transit street transit street st	dical Examiner	23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if the sequentially list conditions, if the sequentially list conditions, if the sequentially list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to for as a	ardice	Arre.	s F		- Dise	Approximate Interval Between Onset and Death
. Box 6	death certii e attending id for use a	hysiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tin 9□Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver	y Day Year
ras, P.	w requires that the been signed by th should be detache	by P	Part II. Other significant conditions of	ontributing to death but		derlying cause give	en in Part I.	23e. Did tobacc	co use contribute to the	
Lec	The law ate has b page 2 si	Completed	Seina	D-3			-	24a. Was an autopsy performed 1 Yes 2	prior to com death?	sy findings available pletion of cause of
ion of vital	ng Phye fter this ineral di	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	28b. Time of	28c. Injury Work	Nursing Hom		6 ☐ Other (Specify,	
DIVISION		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, stre Specify)	et, factory, office	28	Bf. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	one)	ysician: To the best of r siner: On the basis of ex and manner stated	amination and/or inv	occurred at the tim estigation, in my op	e, date and place, an inion, death occurred	nd due to the cause d at the time, date a	(s) and manner as sta and place, and due to	ted. the cause(s)
	a division of the second of th	Σ	29b. Signature and the of certifier	1		29c. License	number 4 2 9 5 5	29d. [Date signed (Month, D	ay, Year)
			30. Name and address of person who	complete cause of deat	h (Item 23a) (Type, F	rint) Edger	V. Potter	Jr.M.	D-32	/
	Sta Registra		31. Date filed (Month, Day, Year) DEC 2 9 20	32. Pogistrar's	Signature	Sporks	/			

			1 - For Stete Registrar	State	of Marylar	•	artment rtificate			and M		giene Reg. No.	2(004	42	703
			Decedent's Name (First, Mic.	ldle, Last)							2. Date of De.	ath Day		Year	3. Time of	
	Physici /Medic			Mary Eli	zabeth A	Appleby	7				Decemb		9, 2	2004	11:40	J P _M
7	Examin		4a. Facility Name (If not institut	ion, give street and n	umber)		4b. City, 7	Town, or	Location c	of Death		4c.	County	of Death		
			St. Mary's Nur						nardtow				Sain	t Mary		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.	90 Yrs.	If Under	1 Year Days	If Under	Min.	8. Date of Birt (Month, Da			9. Birthpl Coun:	ace (State o try)	or Foreign
	Director		220-28-5059	10 24		70 115.					October .	5, 19.	L4	Mary	Land	
	and and		Usual Residence of Decedent 10a. State 10b. Cour	ity	10c. Ci	ty, Town or Lo	ocation							10	Od. Inside Ci	ity Limits
	f sho	ō		. M		T									1 🗌 Yes	2 No
	289-	Director	Maryland Sai 10e. Street and Number	nt Mary's		Leonar	10f. Zip	Code				10g. Citiz	en of V	What Coun	try?	
	with 3a or		22680 Cedar Lane	Count				2065	-0				USA			
	ms 2	by Funeral	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13.	Was Decede			gin? (Spe	ecify Yes or No Rican, etc.)	- 1	4. Rac	e - America		
ເດ	or Ite	Ē	1 Never Married 2 M	arried 1 ☐ Yes	Forces? 2 1 No					i, Puerto	Rican, etc.)			k, White, 6		
ğ	ral', c	by	3	ed If Yes, 0 Year or	Dates:		1 ☐ Yes 2	No LAN	Specify:				Specify	/: Whit	:e	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28e-f show int, the Medical Examinational be multified at	Completed	15. Deced	ent's Education hest grade completes	d)	16a. Dece	dent's Usual kind of work DO NOT use	l Occupa	ation during most	t of worki	ng	16b. Kir	nd of Bu	usiness/Ind	ustry	
7	ithin Ben Ben	du	Elementary/Secondary (0-12		(1-4or 5+)	life.	DO NOT use	e retired	1)							
7	ed w ygier ner th	So	7			Receip	t Conti	rol (vernme	nt	
D L	be fil d oth	Be	17. Father's Name (First, Midd	e, Last)					18. Mothe	er's Name	(First, Middle,	Maiden .	Sumam	10)		
3	should be and Mental I was marked o	2	James Edward Bra								Cecelia					
Maryland	12 sh		19a. Informant's Name/Relatio								il Route Numbe		Town,	State, Zip	Code)	
	1 and tealth sm 27 ther tr		Betty Lou Nelson 20a. Method of Disposition	/ Granddaugh		P.O. Place of Dispo			naptico		yland 20		nation -	City or To	um State	
O.	Pages nent of Hant; If Ite		1 X Burial 2 ☐ Crematio		1 ,	cemetery, cre	matory or ot	her plac	(e)	Janu		200. L00	ation .	City of Tot	vii, State	
Ë.	tant:		14 □ Donation 5 □ Other		St.	James C			4	3, 20	05	Lexing	gton	Park,	Maryla	nd
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examination in a bonce.		21. Signature of Funeral Service	ce Licensee		Ma	2. Name and ittingle	ey~Ga	ırdiner	Fune	ral Home	, P.A.				
			23a. Part1. Enter the disease,	or complications tha	t caused the deat						n, Maryla)650		Approximat	re.
	Pnysician /Medical		shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	ist only one cause or a Due t	n each line.	iral	ory	F	ril	W	0				Interval Bet Onset and I	ween
	Examiner			500	Con	Ester	رااء	lon	N	F	7. 11.1	24			100kg	
		ē	Sequentially list conditions, any leading to immediate cause. Enter Underlying	b. Due t	o lor as a conse	uence of):	00	lecce	,01	10						
	uted d ansit	Examiner	Cause (Disease or injury that initiated events		TENIA	ther-	(a)	no	RIT	> _					41) _
ó	te be executed ysician and ie burial-transit	Exa	resulting in death) Last	Due t	o rras roons	uence of);									1	
3760,	te be ysicia ne bu	cal		d	<u> </u>											
39	eath certificate be executed attending physician and for use as the burial-transit	Jed	IE EEMALE.	1												
XO	es that the death certifice igned by the attending ph be detached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant		outcome of pregn. birth 2 Feta		□Ectopic pre	egnancy	,			2		e of deliver		· · · · ·
œ.	0 0	sicle	in the past 12 months? 1 Yes 2 No		gnant at time of o		Other (spe						Mo	nth	Day ^	Year
P.O.	at the by the	h	9 Unknown													
Records,	- v -	by	Part II. Other significant cond	itions contributing to	death but not res	sulting in the u	inderlying ca	iuse giv	en in Part I.						e cause of dably 4 🔲	
CO	aw requis been 2 should	plet									24a. Was		24b. V	Were autop	sy findings	available
	The law ate has page 2	Completed									autop perfo 1 Yes	rmed?	Ċ	death?	npletion of c 2□ No	ause of
ital	ician: Th certificate rector, pag	0	25. Was case referred to medi	cal					26. Place	of Death	(Check only o					
2	Physician: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗖 DO	A Oth	er: 4 🏿 Nu	rsing Hor	me 5 Resid	dence 6	Oth	er (Specify)	
Division of Vital	Jing After	Certification; 7	27. Manner of Death 1 Natural 5 Pen 2 Accident inve	28a. Da ding (Mo stigation	te of Injury onth, Day Year)	28b. Time o Injury	of 28	Bc. Injun Worl	yat k? Yes 2 □ I		28d. Describe h	now injury	occurr	ed		
N S	or Attencatter death	ifica	3 ☐ Suicide 6 ☐ Cou	ld not be 28e. Pla	ce of Injury - At h	ome, farm, st	reet, factory,	office	-	- 2	28f. Location (S			er or Rural	Route Num	nber,
Ö	s afte	Cert	4 Homicide	bui	lding, etc. (Speci	ny)					City or Tov	vn, State)				
	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	edical (ying Physician: To tall Examiner: On the												;)
	To the within 2 To the comple	Me	29b. Signature and title of cert	fier		. A Y	29c.	Licens	e number	. 10	>			(Month, E		-
			ham	all bo	MAS	M	II) /	1164	H/7		12	, -	30-C	14	
			30. Name and address of pers	on who completed ca	use of death (Iter	23a) (Type,	Print)			1		-				
			James F. Jarboe,	M.D. 24035	Three No	tch Road	d, Holly	ywood	i, Mary	land	20636					
	Sta		31. Date filed (Month, Day, Me	a 3 2885 32			Back	9								
	Regist	ar	V 4.44			- 06		ii)								

			1- State of Maryland / De Registrar 24a,26 per Dr.,G83	partment of Health and M 01/2//05dhb èrtificate of Death	ental Hygie	ne 2004 42704
96	Dhysisi		Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year 3. Time of Death
	Physici /Medio		MARTHA INEZ BISHO			24, 2004 3:39 P ^M
2	Examir	er .	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Casey House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Rockville If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomery
*	Funeral Director		216-18-0609 Usual Residence of Decedent	Months Days Hours Min.	(Month, Day, Ye	ear) 9. Birthplace (State or Foreign Country) L923 Maryland
	land ow		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Many Field	to	Md Montgomery Bro	okeville		1 ∑Yes 2 ☐ No
	h the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	th wit		20601 New Hampshire Ave,	20883	J	J.S.A.
36	ba filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or Itams 23a or 28a-1 show event. The Modifiel Examinational De Invillied at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 Mo	3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	in 72 hou in "natura Vedical E	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ve kind of work done during most of worki b. DO NOT use retired)	ng 16t	D. Kind of Business/Industry Fairland
212	a filed withi al Hygiene. I other than vent, the M	mo;	8th Grade Ni	rsing Aide	Nu	rsing Home
nd	al Hygi al Other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai	den Surname)
yla	2 should ba f and Mental H is marked of raumatic eve	70	Joseph Thornton	Martha	Pumphr	
Maryland	alth and 25 sh			illing Address (Street and Number or Rural 09 Robey Ave, Be		
ore,	es 1 a of He of He fitem		cometen/	position (Name of rematory or other place)	ate 200	c. Location - City or Town, State
Ĕ	mit. Page partment. cortant: If		1 1 2 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Md Vet	erans Cem, 12/30	0/04 Ch	neltenham, Md
Baltimore,	parmit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury 50 other traumatic es once.		21 Signature of Funeral Service Literate	22. Name and Address of Facility Snowden Funera 246 N. Washing	L Home F	P.A. 20850 Rockville, Md
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition CEREBROVASC	ULAR DISEASE		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
Ь		7	Sequentially list conditions, b. DIABETES If any, leading to minimize date. Due to (or as a consequence of):	MELLITUS		
	nted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury			
<u>,</u>	execu n and ial-tra	Еха	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
8760,	cate be executed physicien and s the burial-transit	dicail	d. =			
9	tificat ig phy as thi	ledi				
.O. Box	that the death certificate be executed ed by the attending physicien and detached for use as the burial transit	Physician/Me		B Ectopic pregnancy		23d. Date of delivery Month Day Year
Ω.		by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ord	w requires been sign should be	ted t			1 🗆 Yes	2 XNo 3 ☐ Probably 4 ☐Unknown
Vital Records,	a law has b	Completed			24a. Was an autopsy performed 1 ☐ Yes 2 🔀	
ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	26. Place of Death		
of \	Physician: r this certific ral director,	P	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa			e 6 ۝Other (Specify) Hospice
ū	ing P	on;	27. Manner of Death 1 ∑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	/ Work?	8d. Describe how i	njury occurred
<u>S</u>	Attending r death. actor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No		
Division	or Dir	Certification;	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town, S	t and Number or Rural Route Number, tate)
_	To the Hospital or within 24 hours after To the Funaral Dir completely filled in		29a. Certifier MCertifying Physicien: To the best of my knowledge, de	ath occurred at the time, date and place is	nd due to the cause	e(s) and manner as stated
	n 24 h	edical	(Check only 2 Medicel Exeminer: On the basis of examination and/or one)	investigation, in my opinion, death occurre	ed at the time, date	and place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of continer	29c. License number	29d.	Date signed (Month, Day, Year)
	10		MANUAL STATES	V D41218	1	2/24/04
	(-		30. Name and address of person who completed cause of death (Item 23a) (Typ			20855
			Dr Charles Harrison M.D.	6001 Muncaster	Mill Ro	l, Rockville, Md
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 9 2004 32. Registrar's Signature	Sporks		

		1 - State Amend Item 1. Decedent's Name (First, Middle, Las		, ,	e i iiicat	e oi D	ealli	2. Date of D		104	1270
Physici		Edward Charles	•	1.				Month	per 24,	2004	3.11 Into of Details
/Medic		4a. Facility Name (If not institution, give			4b. City.	Town, or Lo	ocation of Death			aty of Death	11:10 A
CAGIIII		904 Kings Valley	Drive				lville			nce Ge	orges
Funeral		Social Security Number 6. Security Number		ge (In yrs. last birtho	(ay) If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Bi	irth		place (State or Fore
Director		294-03-0107	MM 2□F	85 Yr	i. Worturs	Days	HOUIS MIN.	Dec. 2		Ohi	
* -		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location					1	0d. Inside City Lin
ë ë	ō	Maryland Prince Ge								- 1	Y Yes 2
Department of Health and Mential Hygiene. The most and the marked other then "netural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examinet must be notified at once.	rec	10e. Street and Number	eorges	Mitchel.	10f. Zip	Code			10g. Citizen o	f What Cour	
38 0	D	904 Kings Valley	Drive		2	0721			USA		,.
ems L	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	3. Was Deced	dent of Hisp	anic Origin? (Sp Mexican, Puerto	pecify Yes or No	o- 14. Ra	ace - Americ	an Indian,
a a	y Fu	1 Never Married 2 XMarried	1X Yes 2 □	No	1 Tes, spec		Specify:	Hican, etc.)		ack, White,	etc.
ural.	d by	3 Widowed 4 Divorced	Year or Dates:	'41-'47					Spec	Wh	ite
"nel	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. De	cedent's Usua	al Occupation rk done duri	on ing most of work	ting	16b. Kind of	Business/Ind	dustry
ther The M	omp	Elementary/Secondary (0-12)	College (1-4or	5+) C1e		se retired)			D	4.1	
other rent,	Be C	17. Father's Name (First, Middle, Last)		1 016	: LK	18	B. Mother's Nam	e (First, Middle		tal	
rked lic ev	To B	Thomas J. Burke				C	atherin	e Micha	ω1e	•	
s ma		19a. Informant's Name/Relationship (T	ype, Print)	19b. M	ailing Address		d Number or Rui			n, State, Zip	Code)
n 27 Ier tre		Betty J. Burke/ Wi	lfe	904	Kings	Valle	y Drive	Mitche	11vi11e	,Mary	land 207
if Iter		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ I	Removal from State	20b. Place of Di cemetery,	sposition (Nan	ne of ther place)		Date	20c. Location	· City or To	wn, State
ury o		* 4 □ Donation 5 □ Other (Specify,		Ft. Line	oln Ce	meter	y 12/2	9/2004	Brentwo	od, Ma	aryland
Import any in		21. Signature of Funeral Service Licens	see		22. Name an	d Address o	of FacilityRob	ert E.	Evans F	unera	l Home
7 = 6 0		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of					olis Ro			land :	20715
physician and street transit sthe burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of): a consequence of): a consequence of):							
igned by the attending be detached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions co	4□Pregnant a 9□Unknown	2 Fetal death t time of death out not resulting in the	3 □Ectopic pre 5 □ Other (spe e underlying ca	ecify)	n Part I.		obacco use con	tribute to the	ry Day Year cause of death'
been si	etec	2173610	7	753)	1176	11		, u	193 2 10	3 F1008	Unkne
certificate has rector, page 2 s	e Completed	25. Was case referred to medical						1□ Yes (osy prmed? 2 No	Were autop prior to com death? 1 \(\sum \text{Yes} \)	sy findings availa pletion of cause of
W T	0 13	examiner?	Hospital:	ent 2 ER/Outpat	iont 2 DO		 Place of Death Nursing Ho 				
5 =	L :	27 Manner of Death	28a. Date of Inju	ry 28b. Time	of 28	c. injury at			now injury occur	ner <i>(Specify)</i> red	
ctor: After	atio	2 Accident 5 Pending investigation	(Month, Da	y Year) Injur	М	Work? 1 ☐ Yes	2 🗆 No				
rel Director: led in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In	ury - At home, farm, c. (Specify)	street, factory,	office		28f. Location (5 City or Tox	Street and Numi vn, State)	ber or Rural	Route Number,
To the Funerel Dire completely filled in b	edicai	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exami	sician: To the best ner: On the basis o and manner st	t examination and/or	ath occurred a investigation,	it the time, o	date and place, and place, and death occurred	and due to the ded at the time,	cause(s) and made and place,	anner as sta and due to t	ted. the cause(s)
를 윤	Σ	29b. Signature and title of certifier	1,1)-	29c.	License nu	mber		29d. Date signe	d (Month, D	ay, Year)
To th		7/1	// /	/		_		Į.			
To th		30. I an address of person co	4/150	unin		DZ	8075		DECEMI	35,00	27,200

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Maria Bi ron 12 29 /Medical 04 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Salisbury
If Under 1 Year | If Under 24 Hrs. Wicomico 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🕅 F 88 Yrs. Director 213-12-5507 11/19/1916 Iowa Usual Residence of Decedent with the Manyland 10a. State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits traumatic event, if a Medical Examiner must be nutified at Director Maryland Wicomico Salisbury 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Hall Drive or Items 23a 21804 Funeral USA death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No white Be Completed by 3 ☐ Widowed 4 X Divorced "natural" 16a. Decedent's Usual Occupation
16a bind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done do life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) 12 EKG Technician Hospital 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dr. J. Harry Biron Helen Hockensteiner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lester Simpson/attorney PO Box 766, Salisbury, MD 21803 Pages 1, ent of Hea other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any Injury or mjury or □ Donation 5 □ Other (Specify) Salisbury Crematory 12/30/04 Salisbury, MD 1. Sign ture of Funeral Service Licensee 22 Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CFSP Approximate Interval Between Onset and Death Immediate Cause (F disease or condition resulting in death) mediate Cause (Final **Physician** weart congestire Culia 3. years /Medical Due to (or as a consequence of): Examiner amary unknows artin arsease Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ue to (or as a conseq nonce of): To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? ascular Phria 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate (Imal 2 No 2□ No 1 Yes Be 25. Was case referred to examiner? pedical 26. Place of Death (Check only one) Hospital: 1 Nepatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes 2 LNe this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural death. 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature-and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29/04 D 15384 ennel odrug al

Registrar

State

S. DIVISION

21804

MD

SALISBURY

30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

WENRICH

1346

			For State Registrar	State of N	Marylan	d / Depa <i>Cer</i>	artment of H	lealth and I Death		giene 20	04	42707
			Decedent's Name (First, Middle, La	ist)					2. Date of Dea	th		3. Time of Death
	Physici /Medio		CARRIE CHASE BISH	lOP					Month / 2	Day 27	Veer O4	9.05PM
	Examir		4a. Facility Name (If not institution, given ATLANTIC GENERAL		er)		4b. City, Town, o	r Location of Death	ר	4c. County	of Death	FR
	Funeral		Social Security Number 6.3	Sex 7.	Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs.				lace (State or Foreign try)
	Director		220-03-3049	1□M 2∏F	8	7 Yrs.	Months Days	Hours Min.	07-01-1	917	MEAR	S, VA.
	anyland ehow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation				10	Od. Inside City Limits
	with the Maryland a or 28a-f ehow	tor	MD WORG	CESTER	POC	OMOKE (CITY					1 ☐ Yes 2 🎇 No
	or 28	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of V	Vhat Coun	try?
	death w		4521 SCOTTY ROAD	T			218	·		US		-
36	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hygiene. If Item 27 le marked other than "naturel", or Iteme 23a or 28a-f ehos or other treumatic event, itte Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give	s? ∏No	lf	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		k, White, e	etc.
Maryland 21215-0036	2 hour		3 ₩ Widowed 4 □ Divorced	Year or Dates ducation	s:	16a. Deced	ent's Usual Occup	ation		16b. Kind of Bu	VV 11.	LTE
215	thin 72 e. en "na Media	Completed	(Specify only highest gra Elementary/Secondary (0-12)		or 5+)	(Give I	kind of work done OO NOT use retired	during most of wor	king	TOD. KING OF BO	3111033/1110	ustry
121	led wi lygien her th		12			H	OMEMAKER				HOME	
and	d be fi) Be	17. Father's Name (First, Middle, Last						ne (First, Middle, I		e)	
aryl	should nd Me mark umatic	၉	HENRY LAWRENCE CH 19a. Informant's Name/Relationship (19b. Mailing	Address (Street	CARRIE M and Number or Ru	IAE THORN ral Route Number		State. Zip	Code)
	ss 1 and 2 of Health a litem 27 le		MARY JANE MASON -	DAUGHTER				DAD, POCC				
Baltimore,	permit. Pages 1 Department of He Important: # Iten eny injury or oth		20a. Method of Disposition 1		te Ce	emetery, crem	sition (Name of atory or other place S CEMETE	· 1	Date -2004	20c. Location -		wn, State
altir	mit. P partme portan y injur		21. Signature of Funeral Service Lice	•	WE			ss of Facility BO		VIRGI ERAL HO		INC.
<u> </u>	permi Depa Impo eny ir		1//ll/550 kg	Heun		70	O5 EAST N	MAIN STRE	ET, SALI	SBURY,		LAND 21804
-			23a. Part . Enter the disease, or com shock, or heart failure. List only	plications that cads one cause on each	ed the death line.	. Do not ente	r the mode of dyin			est,		Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	-		12500	111	dery	but			Onset and Death
20	Examiner			Due to (or a	as a consequ	ence of):						/
141		ner	Sequentially list conditions, if any, leading to immediate	b. — Due to (or a	is a consequ	ence of):						
CI	be executed sician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to for a	is a consequ							
7-200 3-200 8760,		dical E		Due to (or a	is a consequ	ence oi);						
7 68	tificate ig physi as the t			. 0.								
7-2-30 30x	death certifi e attending id for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnan		Ectopic pregnancy				of deliver	,
6.0.	0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□ Unknown			Other (specify)			Mon	th [Day Year
0.00	= 00	by Pr	Part II. Other significant conditions of	ontributing to death	but not resul	iting in the und	derlying cause give	en in Part I.	23e. Did tob	acco use contri	bute to the	cause of death?
2 Pro									1 □ Ye	s 2 1 No	3 🗌 Proba	bly 4 🗆 Unknown
7. C	e law re has be	Completed							24a. Was ar autopsy	24b. W	ere autop	sy findings available pletion of cause of
al F	ician: The l certificate ha								perform 1 Yes 2	190 / 06	eath? Yes 2	
୍ ଅ≩	99 10 =	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	tient 2 🗆 E	:R/Outpatient	3□ DOA Othe	200	h (Check only one		. (6	
dod.	ng Phy ter thi neral o	n: T	27. Manner of Death	28a. Date of In	jury :	28b. Time of Injury	28c. Injury Work	The state of the s	ome 5 ☐ Resider 28d. Describe ho			
5. 45. S.	ittending death. stor: Afte / the fun-	catic	1 ☐Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	n			M 1 🗆 '	res 2□No				
Divi	Hospital or Attending 44 hours after death. Funeral Director: After tely filled in by the fune	Certification:	4 Homicide determined	286. Place of Ir	njury - At hon etc. <i>(Specify)</i>	ne, farm, stree	et, factory, office		28f. Location (Str. City or Town,	eet and Numbe , State)	r or Rural i	Route Number,
	Hospi 4 hou Funer tely fill	edicai	29a. Certifier 1 Cartifying Ph (Check only one) 2 Madical Exam	ysician: To the bes niner: On the basis and manner s	or examination	rledge, death on and/or inve	occurred at the timestigation, in my op	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and man te and place, ar	ner as stat nd due to t	ted. he cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	11/1	/	,	29c. License	number	29	d. Date signed	(Month, Da	ay, Year)
	4.0) /	den -	ph	45140	V 44	14283		12/2	7/0	4
L	1111		30. Name and address of person who Robert D	completed cause of	death (Item)	33 / 1	terlhu	24 D	we.	Ber O.	<i>j</i>	211)
not, des	Stat Registra		31. Date filed (Month Day, Year) DEC 2 9 20	32. Regis	trar's Signatu	Jre &	Sparks					

Please Type or Print in	Black Indelible Ink.	Ensure All Copies	Are Legible

			1 - For State Registrar	State		•		t of H	ealth a		lental Hygi	g. No. (200	4 4270
	Physici /Medic		Decedent's Name (First, Mi BERTHA WEIS								2. Date of Death Month DECEMBER	Day 20	Year 2004	3. Time of Death 5:10PM M
	Examir		4a. Facility Name (If not institu	CE HOUSE				EAS	Location of TON If Under		0. Data of Bigh	4c. Co	TALB(OT
	Funeral Director		5. Social Security Number 195-05-0932 Usual Residence of Decedent	6. Sex 1 M 2 X	7. Age (In yrs. 90	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month Day, OCT 30 1	914		hplace (State or Foreign nuntry) RGINIA
	e Maryland 8e-f show lifted at	Director	10a. State 10b. Cou	nty LBOT	10c. Ci	ST. MI	CHAEL							10d. fnside City Limits
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show may injury or other traumatic event, the Medical Evantriar must be notified at Once.	Funeral	10e. Street and Number 23672 MT PLE 11. Marital Status 1 Never Married 2 N	12. Was D Armed	ecedent Ever in U Forces?	J.S. 13.	Was Decedif Yes, spec	216 dent of Hi cify Cuba		gin? (Spe i, Puerto	acify Yes or No-Rican, etc.)	14.		SA rican Indian, e, etc.
21215-0036	thin 72 hours e. e. an "natural", Mudical Exa	Completed by		dent's Education hest grade complete	r Dates:	16a. Dece	dent's Usua kind of wo DO NOT us	al Occupa	ation	t of work	ing 1		of Business/	
Maryland 21	uld be filed wil Aental Hygien rked other th tic event, the	To Be Con	17. Father's Name (First, Midde ANDREW WEIS		TN .	Е	OMEMA	KER			PIATKA		HOME	
	and 2 should lealth and Meni m 27 Is marken her traumatic		19a. Informant's Name/Relation				•	,			ELS, MD			Zip Code)
Baltimore,	Pages 1 and of He ant: If item		20a. Method of Disposition 1 Burial Crematio 4 Donation 5 Other		om State	Place of Dispo cemetery, crea ESAPEAK	matory or o	ther place	1		2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		ion - City or	
Balt	permit. Departr Imports any inj		21. Signature of Funeral Serv	Ostrouski	C.f. S.D	F		S, H	ELFEN	BEIN	& NEWNA			HOME PA
,	Physician /Medical		23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)	a		care	ter the mod	e of dying			r respiratory arres		red	Approximate Interval Between Onset and Death
0,	Examiner and purial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	to (or as a consecto (or as a consecto (or as a consec	quence of):								
68760	rtificate be ng physici as the bu	Medical	IF FEMALE:	d										
.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Liv 4 ☐ Pr	outcome of pregner birth 2 Feta egnant at time of diknown	afdeath 3]Ectopic pr] Other (sp					23d	Date of deli Month	very Day Year
<u>a</u>	w requires that the de been signed by the a should be detached f	by	Part fl. Other significant cond	ditions contributing to	o death but not res	sulting in the u	nderlying c	ause give	n in Part I.				contribute to o 3 ☐ Pro	the cause of death?
al Records,	: The law recate has be	Completed									24a. Was an autopsy perform		4b. Were au prior to d death? 1 ☐ Yes	topsy findings available completion of cause of
Division of Vital	Jing After fune	atlon: To Be	25. Was case referred to medexaminer? 1 Yes No 27. Manner of Death Naturaf 5 Per 2 Accident	Hospitaf: 1 28a, Da	☐ Inpatient 2 ☐ Ite of Injury Ionth, Day Year)	ER/Outpatier 28b. Time o Injury		8c. Injury Work	⁰ Γ: 4 🗍 Nu	rsing Ho	me 5 Residen Residen Rescribe how			HOSPICE
Divis	el or Atte s after de: al Directo	Certification:	3 Suicide 6 Cou 4 Homicide det	ald not be armined 28e. Pla	ace of fnjury - At h ilding, etc. (Speci	iome, farm, str	reet, factory	, office			28f. Location (Stre City or Town,		umber or Ru	ral Route Number,
	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical		lying Physician: To cal Examiner: On the and m			vestigation,	in my op	inion, dea		ed at the time, dat	and pla	ce, and due	to the cause(s)
)	To t To t	M	29b. Signature and title of cer	ifier Milky	how	,	290	. License	number	593			gned (Month	n, Day, Year) A
_			30. Name and address of pers					VE E	ASTON	, MD	21601			
	Sta Regista		MTCHAEL D. (31. Date filed (Month, Day Y	C 2 3 2004	Registrar's Sign	ature	Burk	1						

			1- State of Maryland / Department of Health and M Certificate of Death	ental Hygie	Z 11 11 4 4 2 7 11 9
	Division		Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year 3. Time of Death
	Physicia /Medic			December	- 29 2004 12 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) ST. THOMAS MORE NURSING & REHAB. HYATTSVILLE		4c. County of Death PRINCE GEORGES
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign
	Director		230-22-4383 1 Months Days Hours Min.	3 - 20 - 1 S	922 NORTH CAROLIN
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Maryl -f eho fied a	ţo	MD PRINCE GEORGES HYATTSVILLE		1∭Yes 2□No
	h the	by Funeral Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
	23a c	raid	4821 RUSSELL AVENUE 20782		U.S.A.
	er de items	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ □ No	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	urs aft	by	1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No If Yes, Give 1 □ Yes 2 ▼ No Specify: Year or Dates:		Specify: BLACK
S S	within 72 hours after death with the Maryland ene. then "netural", or items 23e or 28a-f ehow the Modical Exeminer must be notilied at	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working the completed)		. Kind of Business/Industry
21215-0036	vithin ne. hen "	mpf	Elementary/Secondary (0-12) College (1-4or 5+) iife. DO NOT use retired)		
	filed v Hygie other i		2 n d LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Meio	ANUT FACTORY den Sumame)
lan	tould be Mental Parked o	To Be	ULESS BRITT LILLIE	E MAE	BLOWE
Maryland	and N is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura		
	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. item 27 is marked other then "netural", or items 23e or 28a-f ehow other traumatic event, the Medical Examinal must be notified at		SHARON LEE - GRANDDAUGHTER 4821 RUSSELL AVE., 20a Method of Disposition (Name of Disposition		LLLE, MD 20782 Location - City or Town, State
Baltimore,	ages int of H		1 Durial 2 □ Cremation 3 □ Removal from State		
틀	permit. Pages . Department of H Important: If ite eny injury or ot		*4 Donation 5 Dother (Specify) FIRST BAPTIST CEM. 1 - 01 21. Signator of Fuerral Service Decades 22. Name and Address of Facility FAT		VERN, N. CAROLINA UNERAL HOME, INC.
ä	Departi Departi Impo eny ir		301 PARK STREET,	SEABOA	RD, N.C. 27876
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	r respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Antomos denote Canclico V As u	van Di	Onset and Death Jeans
	/Medical Examiner		Due to (or as a consequence of):		200
		Jer	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying		
	cate be executed physician and ithe burial-transit	Examin	Cause (Disease or injury that initiated events c.		
8760,	be exe	al Ex	resulting in death) Last Due to (or as a consequence of):		
687		edical	d		
Box	death certifica e attending ph e for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery
B	0 0 0	sicla	1 ☐ Yes 2 ☑ NO 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month Day Year
P.O.	The law requires that the ate has been signed by the bage 2 should be detache	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Division of Vital Records,	uires tha signed d be del	d by	Cerebral in Fanction	1 □ Yes	2 ☐ No 3 ☐ Probably 4 ☐ Unknown
S	aw requir s been si 2 should l	Completed		24a. Was an	24b. Were autopsy findings available prior to completion of cause of
<u> </u>	The la	mo		autopsy performed	l? death?
/ita	cien: ertifica ector,	Be	25. Was case referred to medical axaminer?	(Check only one)	
_	Physicien: r this certifica ral director, p	J.		ne 5 Residence 28d. Describe how in	e 6 ☐Other (Specify)
on	ding h. After funer	tion	27. Manney of Death 28a. Date of Injury 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of Injury 48c. Injury at Work? 48c. Injury at Work? 48c. Injury at Work? 48c. Injury at Work? 48c. Injury at Work? 48c. Injury at Work? 48c. Injury at Work?	Edd. Describe now i	muly occurred
Visi	Attending or death. ector: After by the fune	Certification;	a Could not be	28f. Location (Street City or Town, St	t and Number or Rural Route Number,
Ö	itel or A rs after el Directed in by	Cert	Dullding, etc. (Specify)	Only of Form, Of	lato)
	Hospitel	Medical	29a. Certifier (Check only one) 29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.		
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Mec	one) and manner stated. 29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, Day, Year)
	FSFO		1 Bullen lehren D01853	- De	CEMBER 30, 2004
2	-(3)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parl A. DEVOLEMB 4203 Queens bury Pd H	1. 11.	-11. W.A
1			31. Date filed (Month, Day, Year) 22. Registrar's Signature	941130	18102 (m) sin
	Sta Registr		DEC 3 0 2004 See & Sparle		

Mosi Butler 04-8291 AKG

91			For State	State o	f Maryland / Do	epartment	of Health	and Mental	Hygien	2004	42710
		ė	Registrar 1. Decedent's Name (First, Middle	e, Last)		Jeruncale	oi Deali	2. Date	Reg. No		2 Time of Death
	Physic			hsan	Butler					^y 23, 2004	3. Time of Death 9:28 P M
	/Medi Examii		4a. Facility Name (If not institution			4h City T	own, or Location			County of Death	9.20 F W
	LAGIIII	ICI	Prince George's	_	•	Cheve		or Boatti		rince Geo	orgo!s
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birth	day) If Under 1	Year If Unde	r 24 Hrs. 8. Date	of Birth		
	Director		546-51-0872	1₩ 2□F	30 Yr	s. Months	Days Hours		h, Day, Year) 11974		ace (State or Foreign try)
	p ,		Usual Residence of Decedent 10a. State 10b. County		1.0 0				/ 1 / 1 / 1	TIVEW	TOLK
	aryla shov	-		_	10c. City, Town					10	Od. Inside City Limits
	the M	Director	Md. Princ 10e. Street and Number	e George	s Hyatts						1 Yes 2 No
	with (급				10f. Zip (1 .	izen of What Count	try?
	ns 23	eral	3563 55th Av		edent Ever in U.S.		20784	111000		U.S.A.	
10	r Iten	by Funeral	1 □ Never Married 2 및 Marr	Armed For	rces?	If Yes, specif	y Cuban, Mexica	rigin? (Specify Yes on, Puerto Rican, etc	or No-	 Race - America Black, White, e 	
036	ol', o		3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	re l	1 ☐ Yes 2	No Specify	:		Specify: bla	ck
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or items 23e or 28e-1 show out, the Medical Examinational lex notified at	Completed	15. Decedent (Specify only highes	's Education	16a. D	ecedent's Usual	Occupation		16b. K	nd of Business/Ind	ustry
2	ithin	nple	Elementary/Secondary (0-12)	College (1		fe. DO NOT use	done during mo: retired)	st of working			
21	lygier her th		12		El	ectric				ntracto	r
and	12 should be filed v h and Mental Hygie is marked other t reumatic event, ID	Be	17. Father's Name (First, Middle,	_				er's Name (First, M.		,	
Ž	hould d Mer narke	2		Coward			Lo			tler	
Maryland	d 2 si th an 17 is r		19a. Informant's Name/Relations					er or Rural Route N			
ည်	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23e or 28e-1 show other treumatic event, the Medical Examination ussible routined at		Ayesha White 20a. Method of Disposition	/_wife	20b. Place of D	63 55	th Ave.	.#5 Hyat	tsvil	le, Md.	20784
<u>o</u>	ages ont of t: If if		1 Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from S	20b. Place of D cemetery,	or or our	or piace)				
Baltimore,	mit. Page partment of oortent: If injury or		21. Signature of Funeral Service		George	Wasni	ngton	12/28/04 y Univer	Ade	Iphi, M	
B	permit. Pages 1 and Department of Healt Importent: If item 2' eny injury or other once.		Mary 1	16- 6	064			St., N.W.			20011
			23a. Fart1. Enter the disease, or shock, or heart failure. List	complications that ca							
	Physician		Immediate Cause (Final	only one cause on ea	ach in the	51.1	1				Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (r	or as a consequence (f):	pace.	5W-5-	en Mo	und	9	
	Examiner		Sequentially list conditions	b. ————		*					
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a consequence of):						
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с							
8760,	cate be executed physician and the burial-transit		resulting in death, Last	Due to (d	or as a consequence of):						
87	cate ohy the	dical		d							
9 ×	death certific e attending pl d for use as t	/Me	IF FEMALE:	23c If yes outs	come of pregnancy						
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	rth 2 Fetal death	3 Ectopic preg			2	3d. Date of delivery Month	y ay Year
	0 0 0	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	9 Unknow	ant at time of death wn	5 ☐ Other (spec	:rfy)				
<u>α</u>		by Pr	Part II. Other significant condition	ns contributing to de	ath but not resulting in th	e underlying cau	se given in Part I	. 23e. I	oid tobacco u	se contribute to the	cause of death?
Vital Records,									_		oly 4 □Unknown
00	swrequi	lete						24a V	Vas an	24h Ware autono	y findings available
R	9 4 9	Completed					···	a	utopsy erformed?	prior to comp death?	pletion of cause of
ita	icien: Th certificate rector, pag	O	25. Was case referred to medical				26 Place	of Death (C eck of		Yes 2	□ No
of <	S S S	To B	examiner? 1 XX es 2 □ No	Hospital: 1 In	patient 2 2 ER/Outpa	tient 3 DOA	Other	Irsing Home 5 F		Other (Specify)	
	ding Pt h. After tt funeral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Dale of			Injury at Work?		be how injury		
Si Si	Attending r death. ector: After by the fune	cati	2 Accident investiga	ation 12/2	3/04 704.	ン M	1□Yes 4	No Sc	hie	1 Sti	A
Division	or Attendate after death Director:	Certification:	3 Suicide 6 Could no determine	ned lee. Flace o	of Injury - At home, farm, g, etc. (Specify)	street, factory, o	office	28f. Location City or	n (Street and Town, State)	Number or Rural F	Route Number,
	pitel purs a nurs a nurs a		20-0-17	<u>k</u>	77	201		300	, ,) 3	Mre	25781
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying (Check only one) 2X Medical E	Adminier. On the bas	pest of my knowledge, de sis of examination and/or	eath occurred at investigation, in	the time, date an my opinion, dea	d place, and due to th occurred at the tir	the cause(s) and	and manner as state	ed. ne cause(s)
	o the	Me	29b. Signature and tiple of certifier	and manne	er stated.		icense number			signed (Month, Da	
	1 5 - 5		100	MAN			C.M.E.			per 24, 2	
	1	1	30. Name and address of person w	no completed cause	of death (Item 23a) (Typ				- CCGIIII	JCL 27, 2	
_				5 YCE M			treet, l	Baltimore	, Mary	land 212	01
	Sta		31. Date filed (Month, Day, Year)		gistrar's Signature	Span	18.1				
	Registra	ar	DEC 29	ZUU4 🗚	neva B	japon	KS				

DHMH 17 Rev 1/2001

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Sardar Begum 12/24/04 6:57 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Funeral 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 😡 F Director unavailable 1/2/27 Pakistan Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturet", or Items 23a or 28e-f show you injury og ether traumatic event, If a Modical Examinar must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Be Completed by Funeral 433 Bonifant Rd. 20905 Pakistan 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Asian 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Charag Dean Beguma Bano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zatoon Dastgir/daughter 433 Bonifant Rd., Silver Spring, Md. 20905
20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State *4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Leensee George 12/24/04 Adelphi, Md. Washington 22. Name and Address of Facility Universal Mortuary Priysician /Medical **Examiner** To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

snock, or neart fairure. List on	mplications that caused the death. Do not enter the mode of dying, such as cardi y one cause on each line.	Interval Between
Immediate Causa (Efnal disease or condition resulting in death)	Due to (or as a consequence of):	Onset and Death
Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consequence of):	
	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	23d. Date of delivery Month Day Year
art II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow
		24a. Was an autopsy performed? 1 Yes 2 No
25. Was case referred to medical examiner?	At the second se	ath (Check only one)
1 ☐ Yes 2 No		Home 5 Residence 6 Other (Specify)
27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certified 1 Certifying P (Check only 2 Medicel Exa	hysician: To the best of my knowledge, death occurred at the time, date and plac miner: On the basis of examination and/or investigation, in my opinion, death occ and manner stated.	a, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	. / 29c. License number	29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

within 24 hours a To the Funerel I

7600

32. Registrar's Signature

			_ POF	partment of Health and Mental I	Hygiene Reg. No.2004 42714
			Decedent's Name (First, Middle, Last)	2. Date of	f Death 3. Time of Death
	Physici		Donald Larence Boswell	Month Decen	nber 31, 2004 6:00PM M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			45372 Sypher Road	California	St. Mary's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Min. (Month	, Day, Year) Country)
	Director		578-22-5179 80 Yrs. Usual Residence of Decedent	Feb.	1, 1924 Washington, D.C
	land ow		10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
	Mary -f sh	to	Maryland St. Mary's Califor	nia	1 ☐ Yes 2 No
	within 72 hours after death with the Maryland ene. than "netural", or items 23a or 28e-f show he Medical Examiner must be notified at	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	th wit	alD	45372 Sypher Road	20619	U.S.A.
	ems	iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1.0 4.2	. Was Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Cuban, Mexican, Puerto Rican, etc.	r No- 14. Race - American Indian, Black, White, etc.
ဓ္ထ	s afte	by Fu	1 Never Married 2 Married 1 Never Married 2 No. 1 942	1 ☐ Yes XX No Specify:	Specify:
21215-0036	hour tural'	q pe		edent's Usual Occupation	White 16b. Kind of Business/Industry
5	in 72 na're	Completed	(Specify only highest grade completed) (Gin	e kind of work done during most of working DO NOT use retired)	rob. Kind of business/industry
72	with liene.	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Lumber	Plumbing
ğ	filled Hygid other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mid	
<u>a</u>	uld be Aental rked c	To B	Stanley Boswell	Nellie Goodw	rin
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic avent, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rural Route Nu	umber, City or Town, State, Zip Code)
	1 and 2 Health tem 27			l Chestnut Ridge Dr., L	
ore	of He		1 ▼ Burial 2 □ Cremation 3 □ Removal from State Cemetery, Cl	position (Name of Date ematory or other place)	20c. Location - City or Town, State
Ē	Pag ment ent:		`4 □Donation 5 □Other (Specify) Immacula		Lexington Park, MD
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. signatu — LFD rai Sarvice Lic — se	22. Name and Address of Facility Brinsfi	eld Funeral Home, P.A.
	0.D = 6 0			22955 Hollywood Road, Le	
П			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode or dying, such as cardiac or respirato	ry arrest, Approximate Interval Between Onset and Death
	Physician			NPARCTION	IMMEDIATR
•	/Medical Examiner		Due to (or as a consequence of):	TOO CATE POIL	
		10	Sequentially list conditions, if any, leading to immediate b. DiFPUSR A Due to (or as a consequence of):	LTBRIUSCELORSIS	
	ted nsit	ulu e		THE HARREN BUSIN	U SRVARAL YRARS
<u>_</u> ,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last c. Direction (or as a consequence of):	LITUS / HYPERTENSIUS 8	TELUCEULA
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Ical	d		
9	tificat ng phy as th				
XO	res that the death certific igned by the attending F be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy	23d. Date of delivery
Ö.	ed fo	slcia	1 Yes 2 No	Other (specify)	Month Day Year
P.O.	at the	Phy	9 Unknown	one for the control of the control o	Did tobacco use contribute to the cause of death?
ŝ	signer	by	Part II. Other significant conditions contributing to death but not resulting in the	,···g	Yes 2 No 3 Probably 4 Unknown
ecords,	w requir been si should	Completed		3	
ec	e law has b	nple		a	Was an autopsy findings available prior to completion of cause of death?
E E		S		1□ Y	
Vital	Physician: The riths certificate hiral director, page	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check of Other: 4 D Nursing Home 5 1	
of	S 50	To.	1 Yes 2 No 1 Inpatient 2 EH/Outpati	ent 3 DOA 4 Indising nome 5 12 F	Residence 6 Other (Specify) ibe how injury occurred
O	ding J. Afte fune	tlon	1 Natural 5 Pending (Month, Day Year) Injury		. ,
Division	Attending r death. ector: Afte by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		on (Street and Number or Rural Route Number,
ă	al or safter	erti	4 Homicide building, etc. (Specify)	City of	Town, State)
	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director. completely filled in by the		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, de		
	n 24 n 24 he Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the til	me, date and place, and due to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
)			John L Bennett nD	20019052	113/05
1	100		30. Name and address of person who completed cause of death (Item 23a) (Typ	·	
			John L. Bennett 23263 By The Mill R	oad California, Maryland	1 20619
	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 4 2005	alle	
	negist	cll	OTHER TELEVISION AND AND AND AND AND AND AND AND AND AN		

DHMH 17 Rev 1/2001

ORIGINAL

		•	- State Amend Item	State of Ma 23a per Dr	ryland ••• G83	Depa Ole	rtment of H	ealth and M Death	ental Hyg	giene Reg. No.	2004	42715
			1. Decedent's Name (First, Middle, Last)						2. Date of Dea		Year	3. Time of Death
	Physicia /Medic		Mary Jano Brocato								0510 A ^M	
4	Examin		4a. Facility Name (If not institution, given	4b. City, Town, or Location of Death			4c. County of Death					
			Laurelwood Care Center			E1kton st birthday) If Under 1 Year If Under 24 Hrs.			8. Date of Birt	Cecil B. Date of Birth (Month, Day, Year) AUG 17, 1923 Country Maryland		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland 'O T Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23a or 28e-f show as any injury or other treumatic event, the Medical Examiner must be nufficed at 200.		5. Social Security Number 6. Sex 1 M 2 AF 7. Age (In yi			Yrs. Months Days Hours Min.			(Month, Day			
			218-14-4640 Usual Residence of Decedent		A				, 19.	23 [1161]	yranu	
			10a. State 10b. County		10c. City,	Town or Lo	cation				10	Od. Inside City Limits
		ctor	Maryland Cecil Ell				kton					1 X Yes 2 □ No
		Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Coun							try?		
		rai	100 Laurel Driv			S. 13. Was Decedent of Hispanic Origin? (Specific					ited Sta	
		nue	11. Marital Status 12. Was Deceden Armed Forces 1 □ Never Married 2 □ Married 1 □ Yes 2 □			13. V	Yas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)	· '	Black, White, etc.	
21215-0036		Completed by Funeral	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	If Yes, Give		1 ☐ Yes 2 🛣 No Specify:			Specify: White		
ò		ted	15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupetion (Give kind of work done during most of working				16b. Kind of Business/Industry		
218		nple	Elementary/Secondary (0-12) College (1-4or 5+)			life. DO NOT use retired)			''y			
2		Co	12			Hon	nemaker	40 Mark 4 Mary	(C: .) 11: (d)		Her Own	Ноте
Maryland		Be	17. Father's Name (First, Middle, Last	1)				18. Mother's Name				
7		္	Harry Style 19a. Informant's Name/Relationship (Type, Print) 19b.				Jane Ceceli Mailing Address (Street and Number or Rural Route Nu					
Ma			John J. Huber/Bro				Sweetbri					•
ē,	tem tem		20a. Method of Disposition	Jener III III	20b. Plac	e of Dispo	sition (Name of		ember	20c. Lo	cation - City or To	wn, State
E C	Pages nent of nt: If I		1 ☑Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci			rison eterv	ratory or other place Forest	27.			ngs Mill: vland	s,
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee Picks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921									
		-	23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									
	ding Physicien: The law requires that the death certificate be executed th. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	8 8	Immediate Cause (Final Onset and Death									
4			disease or condition resulting in death) a. Due to (or as a consequence of):									
п			Sequentially list conditions,	b D (Democration Pneumonia							
11		iner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Dementia								
VI		Examin	that initiated events resulting in death) Last C. Due to (or as a consect									
38760,		dicai										
89		edic										
S. Box		by Physician/Me					3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delivery Month Day Year		
P.0		Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did							tobacco use contribute to the cause of death?		
Records,									1 Yes 2 No 3 Probably 4 Junknown			
Sor		Completed		,					24a. Was	an	24b. Were autoc	esy findings available
Re		dmc							autop perfor	rmed?	prior to con death?	rpletion of cause of
ta		0	1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one)									
Ξ		To B	examiner? 1 Yes 2 No									
0	De je	L:uc	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Work?								
Sio	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	atic	2 Accident investigation	be 300 Step of Injury At home form steps of action of				1 ☐ Yes 2 ☐ No				
Division of Vital		Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined				eet, factory, office		 Location (Street and Number or Rural Route Number, City or Town, State) 			
		Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
		Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)								Dey, Year)	
			Macuel D0026183 12,20,04									
	H		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAdhu Sachder, M.D. 322 E. Cecil Ave. North East md 21901									
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature									
	Regist	ar	DEC 2 8 2004 Server & sports									

 $\mathcal{REPLACEMENT}$ Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Richard Leo Collier, Jr. 9:31 P M December 24 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/13/1943 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Yrs. **Director** 213-44-7542 61 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes Ž No Directo MD Harford Aberdeen 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ě Items 23a <u>1338 Perryman Road</u> 21001 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 □ No If Yes, Give Year or Dates: Vietnam 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ♣ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Entertainer Night Club Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Richard L. Collier, Sr. Joyce Fowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent; if item 27 ts Donald B. Collier, Sr. (Brother) 9 N. Rogers St., Aberdeen, Maryland 21001 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Gardens | 12/30/2004 Aberdeen, Maryland 21. Signature of Euperal Service Licensee Tarring-Cargo Funeral Home, P.A. any tr Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 neek /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Be Completed by Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ☐ Yes 2 No 1 Tes 26. Place of Death Hospital: Other: 2 1 ☐ Yes 2 ☐ NO 1 patient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) : After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No after death 2 Accident the 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral C To the Hospitel 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical editiving ringstoni. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number e of death (Item 23a) (Type, Print) 30. Name and address of person who co 32. Registrar's Signature Manue 31. Date filed (Month, Day, Year) State Registrar 2005 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and Me Certificate of Death	Reg. No. 004 42717
	Dbi-			2. Date of Death Month Day Vear
	Physic /Medi		Darnell F. CoulbournE	12 26 04 9:15 p.M
7	Exami	ner	Edward McCready Hos Pital 4b. City, Town, or Loc Crisfic	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Birthplace (State or Foreign
н	Director		330.37-0931	67-24-50 Country) MD
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	or 28s	Funeral Director	10e. Street and Number 10f. Zip Code	10g. Citizen of Whet Country?
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21215-0020	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mentel Hyglene. If item 27 is marked other than "naturel", or items 23s or 28s-f show or other treumstic event, the Medical Examiner must be notified at			Specify: Black
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Maryland	12 sh 10 m		19a. Informant's Namer relationship (Type, Print)	House Number, City or Town, State, 2ip Code)
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Baltimore,	Pagas nent of nrt: If it iry or o		1 X Burial 2 Cremation 3 D Removal from State cemetery, crematory or other place)	-31-4 Marion, MD
alti	- 무급하다		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	orel Homo
©	G E P G	- 0	Anthony E. Ward Sun, 30639 Hampden All	Princess Anne, UD 21853
			23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest, Approximate
\rightarrow	Physician /Medical		Immediate Cause (Final	Onset end Death
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o o	the self	7.7	27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28	d. Describe how injury occurred
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Division	r Atte ter de lrecto n by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)
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	To the Hospital within 24 hours of the Funerel Completely filled	Medical	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, an examination end/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) and manner es stated. I at the time, date and place, and due to the cause(s)
	To the Hospital or Attending is within 24 hours after death. To the Funerel Director: After complately filled in by the funer	×	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
			D47637	12-26-2004
			30. Name and eduress of person who completed cause of death (Item 23a) (Type, Print) TOSEPH J. INZERFLLO, M. D.	11 Hwy CRISfield MD
	Sta	to	31. Date filed (Month, Day, Year) 32. Register's Signature	in umd okistiga IID
	Registr		DEC 2 9 2004 Decre & Angel	

DHMH 16 Rev 6/95

			For State	State of N	/laryland		artment o			nd Ment		ene 1. No. 2 ()	101.	1.2710
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Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from Stat	te C6	emetery, crer	natory or other	er place				c. Location		
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				s A. Prieba) Irvii	ng S	St., N	I.W. #	2151,	Wash.	, DC	20010
	Sta Registr		DEC 3 0	2004 Kor	strar's Signat	Spe	de							

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4 Donation 5 Other (Specify) 12-29-04 Memori permit.
Departmitmportal 22. Name and Address of Facility Chaules 21. Signature of Funeral Servi Himelia Unper Kayak D1 MD 2077. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsey and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner neumonica Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Thriles resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day 5 Other (specify) P.O. 1 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No page 2 autopsy performed 2 X No 1 Yes Hospitel or Attanding Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: Other: P 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide 24 hours after a Funaral Dira letely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0021033 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. Bry CNG LEE 31. Date filed (Month, Day, Year) State DEC 3 0 2004 Registrar

DHMH 17 Rev 1/2001

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20b. Place of Disposition (Name of cemetery, crematory or other parts) itam 27 i MD 20878 Myong f 20a. Method of Disposition Hon Date 20c. Location - City or Town, State Department of Himportant: If its any injury or ot once. 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) BLNEY 3 □Removal from State 12.31-04 memorial Funered 22. Name and Address of Facility CHOLOS Hinds 21. Signature of Fune al Service Licensee Saurie Kayak D1 12303 upper 23a. Part1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a reshock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 Tyes 2 25 No 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown ģ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No 1 Inpatient Other. 1 🗌 Yes 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After t Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Diractor: filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide 24 hours To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

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Registrar DEC 3 0 2004

31. Date filed (Wonth, Day, Year)

Khan 12016 Geo 3 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of M	Maryland	d / Depa <i>Cei</i>	artment rtificate	of H	ealth a Death	and M		giene Reg. No.		. !	+27	21
	Physici	an	Decedent's Name (First, Middle, La.	st)							2. Date of Dea Month	Day	/_Ye	ar	3. Time o	
	/Media	cal	Victoria 4a. Facility Name (If not institution, given	o stroot and number	Co1u	zzi	4b City 1	Four or	Location o	f Dogth	Decemb		27, 20 County of D		4:50	<u>р</u> м
	Examir	ner	Hospice of the C					thic		Dealli			nne A		le1	
ı	Funeral		5. Social Security Number 6. S	ex 7. /	Age (In yrs. la	ast birthday)	If Under Months			24 Hrs. Min.	8. Date of Birt	h			ice (State o	or Foreign
	Director		378-40-1000	□M 2⊠F	90	Yrs.	Montris	Days	Hours	MIN.	July 1	3, 1	914 I	Balt	imore	e, MD
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City	r, Town or Lo	cation							10	d. Inside C	ity Limits
	Mary -f she	to	Maryland Prince	George's	Со	llege	Park								1K Yes	2 🗆 No
	or 28g	Director	10e. Street and Number				10f. Zip					10g. Citi	zen of What	Countr	y?	
	death with the Maryland rms 23e or 28e-f show		8902 34th Avenue						0740				USA			
	be filed within 72 hours after death with the Marylan lat Hygiene. d other than "natural", or Items 23a or 28a-f show event. The M. Clost Examinations to notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 Tyes 22 If Yes, Give Year or Dates	s? ∑No		Was Decede If Yes, speci 1 Yes 2			gin? (Spe , Puerto i	cify Yes or No- Rican, etc.)		14. Race - A Black, W Specify:		tc.	
5	72 ho	ted	15. Decedent's Ed (Specify only highest gra	ducation		16a. Dece	dent's Usual	l Occupa	ation	of worki	20	16b. Ki	nd of Busine	ess/Indu	stry	
21215-0036	Aithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)		kind of worl DO NOT us)	OI WOIKII	19	0	77			
7	Hygien Hygien ther th		17. Father's Name (First, Middle, Last)			ног	nemake	er	18 Mothe	r's Name	(First, Middle,		vn Hom	ie		
and		To Be	Antonio Collin								dina Ga					
Mary	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If Item 27 Is marked other than "Item reaumatic event, ITEM".	-	19a. Informant's Name/Relationship (Туре, Print)							l Route Numbe			e, Zip C	Code)	
-	1 and 2 Health tem 27 l		Richard L. Coluzz	:i - Husb					nue,		ege Par			740		
baitimore	iges 1 and of the corotha		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		. C6	ace of Dispo emetery, cren it Oliv	natory or oti	her place			/2004		cation - City shingt			
	permit. Pages: Department of H Important: If Ite any Injury or ot		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service □ 		Flouri				- 1	-	ch's Fu					
g	Depa Impo	1	Malania Tras	5/101	134:						ue, Hya				207	81
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus one cause on each	sed the death	. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory ar	rest,			Approximat nterval Bet	ween
	Priysician		Immediate Cause (Final disease or condition	Breast	Cance	r – me	etasta	atic						(Onset and i	Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	ence of):										
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	as a consequ	ence of):								+		
	cuted nd transit	Examiner	that initiated events	C												
Ď	the death certificate be executed y the attending physician and iched for use as the burial-transit		resulting in death) Last	Due to (or a	as a consequ	ience of):										
09/89	physic physic s the b	dicai		_ d.										Ť.		
XOD	death certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			7=					2	23d. Date of	delivery	,	
מ	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant 9□Unknown	at time of de		Ectopic pre Other (spe						Month	D	ay ^	rear .
л Э	hat the d by ti	Phy	9 ☐ Unknown Part II. Other significant conditions of			iting in the w	ndorh/ing on	uea ana	on in Part I		23e Did to	paccoli	se contribute	o to the	cause of d	loath?
coras,	w requires that the de been signed by the should be detached	d by	Tankin on the original origina original original original original original original original	og to dod!	7 5 61 11 10 10 10 10	ating in the di	naonying oa	uso give	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		11]No 3 □			
<u> </u>	law req as beer 2 shou	Completed									24a. Was		24b. Were	autops	y findings	available
Ľ	The ite h	lmo									autop perfor	sy med? 211 No	death	to comp 1? /es 2		ause of
VII	clan: ertifica ector,	Be	25. Was case referred to medical examiner?					1		of Death	(Check only or					
5	Physician: this certific ral director,	은	1 ☐ Yes 2 🖾 No 27. Manner of Death	Hospital: 1 Inpa		ER/Outpatien		de la companya della companya della companya de la companya della	4 U Nui	-	ne 5 Resid		Other (S	Specify)	Hosp:	ice
	ftel ine	tion	1 XNatural 5 Pending 2 Accident investigation	28a. Date of Ir (Month, I	Day Year)	Injury	M	3c. Injury Work 1 □ 1	al ? ∕es 2 ∐ N		od. Describe n	ow injury	y occurred			
DIVISION	or Attending ifter death. Director: Aftei in by the fune	Certification:	3 Suicide 6 Could not b	e 28e. Place of	Injury - At hor etc. (Specify)	me, farm, str	eet, factory,	office		2	t8f. Location (S City or Tow			Rural F	Route Num	ber,
5	Ital or irs afte ral Dii lled in			building,							0.1.7 0.7 10.77					7440
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 △ Certifying Ph (Check only 2 ☐ Medical Exar	ysician: To the be niner: On the basis and manner	s of examinati	vledge, death ion and/or inv	n occurred a vestigation,	it the tim in my op	e, date and sinion, deat	d place, a h occurre	nd due to the o	ause(s) late and	and manner place, and c	as stat due to th	ed. he cause(s)
	ro the within ro the comple	Me	29b. Signature and title of certifier	and mariner	Statoo.		29c.	License	number		2	29d. Date	e signed (Ma	onth, Da	ay, Year)	
			I have D.	west	Zni			D23	743			12	2/29/2	004		
2	-(6)		30. Name and address of person who								1					
	Sta	ato.	Martin Weltz, 1 31. Date filed (Month, Day, Year)					Dr	ive,	Ste	205, Gr	eent	elt,	MD 2	20770	
	Registr		DEC 3 0 2004	Berry	strar's Signat	Spar	R									

DHMH 17 Rev 1/2001

				•			Logith and Mor		•	
			1 _ State	State of Ma	-	ertificate of	lealth and Mer		-200h	62722
			Registrar 1. Decedent's Name (First, Middle, Last)			ortinoate or		Date of Death	J. Nd: 0 0 4	3. Time of Death
	Physici		Roger N. Conklin,	.Ir.				Month cember	Day Year	11:40AM
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, o	r Location of Death		4c. County of Death	
		٠	25 Lake Forrest Dr	ive		E1kto			Ceci1	
	Funeral Director		5. Social Security Number 6. Sex 1 🔀	M OFF	e (In yrs. last birthda +7 Yrs.	y) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day,)	9. Birth Co.	nplace (State or Foreign untry) Delaware
-	0		Usual Residence of Decedent					Didary	0, 1557	
	aryian ehow	_	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits 1 ☐ Yes 2 X No
	28a-f	Directo	Maryland Cecil 10e. Street and Number		E1kt	on 10f. Zip Code		100	g. Citizen of What Co	
	WILD WILD			***			1921			
1	ms 23	Funerai	25 Lake Forrest Dri	2. Was Decedent I	Ever in U.S. 1		Hispanic Origin? (Specify an, Mexican, Puerto Rica		nited Stat	rican Indian,
و	De lied within 72 hours after death with the maryland tal Hygiene. Ad othar then "natural", or Itams 23a or 28a-f ehow avant, the Modical Examinal must be notified at		1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 🛣 N If Yes, Give	10	If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	an, Mexican, Puerto Rica Specify:	an, etc.)	Black, White	e, etc. hite
9	ural',	d by	3 Widowed 4 Divorced	Year or Dates:	1 10 D			50		
Maryland 21215-0036	n /2 in Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Gi	cedent's Usual Occup ve kind of work done b. DO NOT use retired	during most of working	10	3b. Kind of Business/l	ndustry	
212	z snould be filed withit and Mental Hygiene. is marked othar than aumatic avant, it was	mo:	Elementary/Secondary (0-12)	College (1-4or 5		eral Manag	ger		Constructi	Lon
_	~ - 0 %	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name (F	irst, Middle, Ma	aiden Sumame)	
<u>a</u>	Venta Venta vrked		Roger N. Conklin, S	r.			Ruth Gr:	imshaw		
<u>a</u>	and I		19a. Informant's Name/Relationship (Typ	e, Print)		,	and Number or Rural Re		,	,
≥	and ealth m 27 her tr		Norma L. Conklin/Sp	ouse			est Drive, I			
Baltimore,	ges l t of H ita or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	moval from State	North E	position (Name of rematory or other plai ast Method	fist Decemb	11 -1	oc. Location - City or	.own, State
## ##	t. Pa rtmen rtant:		'4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License)	Cemet	ery	20, 20	004 No	rth East,	Maryland
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic av <u>once</u> .		21. Signature of Fugeral service/Lichnse				ess of Facility Croud			yland 21901
			23a. Part1. Enter the disease, or complic	cations that sused	the death. Do not					Approximate
	hysician		shock, or heart failure. List only one Immediate Cause (Final	. 1	iple Ma	1				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		a consequence of):	1210ma				12 months
E	Examiner		Sequentially list conditions, b.							
0 -	p =	iner	it any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					
LT.	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to for as	a consequence of):					
60,	be ex ician burial	cai E		Due to (or as	a consequence on,.					
687	phys the	edic	d.							
Вох	nding nding use a	n/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					23d. Date of deli	very
Ď,	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live birth 4 □ Pregnant at 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other <i>(specify)</i> _	у		Month	Day Year
P.O.	at the d by th etache	by Physician/Medi	9 Unknown					OO- Didash		45
Ś	The law requires that the death certificate be executed attents been signed by the attending physician and page 2 should be detached for use as the burial-transit		Part II. Other significant conditions conf	inbuting to death b	ut not resulting in the	underlying cause giv	ven in Part I.		cco use contribute to	
Vital Records,	requ been should	etec						24a. Was an		
Bec	ne law has l	Completed						autopsy performe	prior to death?	topsy findings available completion of cause of
<u></u>	ysician: The lav is certificate has director, page 2	e Co	25. Was case referred to medical				26. Place of Death (C	1 ☐ Yes 2()	No 1 □ Yes	2 No
\$	/sicia s cert directi	To B	eyaminer?	ospital:	ent 2 ER/Outpa	ient 3 DOA Ott	100		ce 6 □Other (Spec	eifv)
ō	g Phy ler thi		27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b. Time	of 28c. Injur	ry at 28d		injury occurred	,//
<u>,</u>	andin sath. or: Afi ne fur	atio	1 Natural 5 Pending 2 Accident investigation	(111111111)	, , , , , , , , , , , , , , , , , , , ,		Yes 2□No			
Division of	To the Hospital or Attending Physician: state as after death: 24 both the Funaral Director: After this certified completely filled in by the funeral director.	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, et	ury - At home, farm, c. <i>(Specify)</i>	street, factory, office	28f.	Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	Hospital of the state of the st		29a, Certifier 1 💢 Certifying Phys	ining: To the best	of my knowledge, de	ath occurred at the ti	me, date and place, and	due to the ear	ico/o) and manner on	etatod
	e Hos 24 ho e Fun etely	Medical		ner: On the basis of and manner sta	f examination and/or ated.	investigation, in my	opinion, death occurred a	at the time, dat	e and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	se number	290	d. Date signed (Month	, Day, Year)
)			My Ferhan	10		715	314	D-	ecember	29,2004
	CI		30. Name and address of person who cor	mpleted cause of d	leath (Item 23a) (Typ	pe, Print)	se number 314 upeake Husp	, .	1/1+	17
			1 turkas, M) 31. Date filed (Month, Day, Year)	Scison &	ar's Signature	orn thes	apeake Husp	ice, E	IKlon,	(V
	Sta Registi		DEC 3 0 2004	A. negistr	. It do	ante				
			DEC 0 0 2004	A. M. Service	34					

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			For State of Maryla		eartment of Health and Mertificate of Death	lental Hygier	Z11111 1. 2.199
	Blue della		Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death
	Physicia /Medic		Betty Lee Chester				²⁵ , 2004 10:50 p M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
	Function		Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age (In y	vrs. last birthday	Annapolis If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Anne Arundel 9. Birthplece (State or Foreign
	Funeral Director		1 N 257 E	77 Yrs.	Months Days Hours Min.	Feb. 11,	1927 Washington, DC
	של		Usual Residence of Decedent	. City. Town or L	ocation		10d. Inside City Limits
	fanyla show	ō		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	s Landing		1 ☐ Yes 2 🔂 No
	28a-1	Directo	Maryland Anne Arundel	Itacy	10f. Zip Code	10g.	Citizen of What Country?
	3a or		6384 Old Solomons Island Road	i	20779		U.S.A.
	ems 2	Funerai	11. Marital Status 12. Was Decedent Ever in Armed Forces?		. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No		1 ☐ Yes 2 ☑ No Specify:		Specify: white
Ş	filed within 72 hours after death with the Maryland Hygiene. the than "natural", or Items 23a or 28a-f show ant, the Macical Examiner must be natified at	ed b	3 XWidowed 4 □ Divorced Year or Dates: 15. Decedent's Education	16a. Decr	edent's Usual Occupation	16b	. Kind of Business/Industry
7.	nin 72 n "na Wedic	piet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	e kind of work done during most of work. DO NOT use retired)	ing	,
212	d with giene er tha	Completed	12	hor	ne maker		own home
nd	be filed tal Hygi d other avant, I	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or litems 23a or 28a-f show armatic avant, the Medical Examination and the notified at	70	Thomas Edward Mulloy 19a Informant's Name/Relationship (Type, Print)	10h Mai	Ing Address (Street and Number or Rura	irginia M	
<u>a</u>	カモトサ		Richard A. Chester, son		Berts Drive, Lothi		
ō,	s 1 and f Health itam 27 other tr		20a. Method of Disposition 20				. Location - City or Town, State
Ë	Page nent o int: If		1 Y Bural 2 Cremation 3 (Regioval from State)			/2004 Su	itland, MD
Baltimore,	permit. Pages 1 and Department of Heall Important: If itam 2 any injury or other once.		21. signature of Funeral Service Licens	1	22. Name and Address of Facility		
	205 2 3		Duya / whart		Rausch Funeral Home		wings, MD 20736 Approximate
П			23a. Part1. Enter the disease, or complications that caused the dishock, or heart dailure. List only one cause on each line. Immediate Cause (Final			or respiratory arrest,	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) Due to (or as a con	leumon	ia		days
B	Examiner			sequence or).			
	DEGL	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying.	sequence of):			
	acuted ind transi	Examiner	cause. Enter Underlying Cause (Disease of Injury) that initiated events resulting in death) Last Due to (or as a con				
8760,	ate be executed obysician and the burial-transit	ai Ex	resulting in death) Last Due to (or as a con	sequence or):			
687	.o d .o	Physician/Medicai	d				
Box (eath certif attending for use as	n/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ F		☐Ectopic pregnancy		23d. Date of delivery
	death ne atte ed for	sicia	in the past 12 months? 1 Yes 2 No 4 Pregnant at time		Other (specify)		Month Day Year
P.0	that the death cer ed by the attendin detached for use	Phy	9 Unknown Part II. Other significant conditions contributing to death but not	ropulting in the	underhien equal enven in Part I	23a Did tohaco	co use contribute to the cause of death?
	ires that signed I	b	Part II. Other significant conditions continuously to death but not	resulting in the	underlying cause given in rait i.	1 ☐ Yes	
20 1	w requir been s should	Completed				24a. Was an	24b. Were autopsy findings available
Re	The lav	dmc				autopsy performed	prior to completion of cause of death?
Vital Records,		· o	25. Was case referred to medical		26. Place of Deat	1 ☐ Yes 2 🗶 h (Check only one)	10 10 20 10
Ž	Attending Physician: r death. ector: After this certific by the funeral director,	To B	examiner? 1 Tes 2 No Hospital: 1 Inpatient	2 EP/Outpatie	ent 3 DOA Other: 4 Nursing Ho	me 5 Residence	e 6 □Other (Specify)
n of	iding Phi th. After the funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Yea	28b. Time Injury	Work?	28d. Describe how in	njury occurred
Division	ttendi death. ctor: A y the fu	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - A	At home farm s	M 1 Tyes 2 No	28f. Location (Street	t and Number or Rural Route Number,
ο̈́	after after Direct	Certification:	4 Homicide determined 259 Flace of Highly 5 building, etc. (Sp	necify)	stration, action, action	City or Town, St	
	To the Hospital or Attend within 24 hours after death To the Funaral Director: completely filled in by the	edical C	29a. Certifier (Check only 2 Medical Examiner: On the best of my 2 Medical Examiner: On the basis of exam	knowfedge, dea	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complet	Med	one) and manner stated. 29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
)	F S F Ö		1/2011 MM		D 46052		12/28/04
	6		30. Name and address of person who completed cause of death Signal Beth, MD 200	(Item 23a) (Type	(al Panhway and	apolis, r	UD
	Sta Regista		30. Name and address of person who completed cause of death of the second secon	ignature	Spertes		

State of Maryland / Department of Health and Mental Hygiene 0 0 [42724 Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 11:05 p December 25,2004 Clark Virginia Betty /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Memorial Hospital Prince Frederick
If Under 1 Year | If Under 24 Hrs. Calvert If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 9. Birthplace (Ste Country)
March 10,1925 Maryland 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 1 ☐ M 21 ☐ F 79 Director 212-24-7873 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County in then "naturel", or Items 23s or 28s-f show the Medical Examiner must be notified at 1X Yes 2 □ No North Beach Maryland Calvert Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20714 U.S.A. 3916 Street 2nd death Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: white þ 3 X Widowed 4 ☐ Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than . College (1-4or 5+) Elementary/Secondary (0-12) home maker own home 8 other permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If Item 27 is marked oths any injury or other treumetic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Estelle Helen Calvert Paddy Morris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6417 Brookside Ct., Chesapeake Beach, MD Shirley Lee Blackwell, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Harmony Cemetery 12/29/04 Owings, MD 4 Donation 5 Other (Specify) 21 Squiture of Funeral Service Ligense 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rena Physician /Medical Due to (or as a consequence of) **Examiner** 4ears pergension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dunto (or as a consequence of) Examine or Attending Physicien: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, eq 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? syndrome 24a Was an 2 No 1 Yes 2 🗌 No 1 Yes Dementia Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No 3 DOA Medical Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. in 24 hour.
the Funerel Dire. 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospitei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert J. Schlager, M.D.

31. Date filed (Month, Day, Year)

DEC 2 9 2004 110 Hospital Rd. Suite 111, Prince Frederick, MD 20678 32. Registro's Signature State Registrar

			1 - For State Registrer		State of Ma	aryland/	-	rtment of t tificate of	Health and N <i>Death</i>		giene Reg. No:()	001	1
				e (First, Middle, Last,						2. Date of Dea	ath 6.0	004	3 Time of Death
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	/Medic Examin			If not institution, give				4b. City, Town,	or Location of Death		4c. C	ounty of Death	1
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	Funeral Director		5. Social Security N 224-05-4	745 ¹ X	7. Ag	e (In yrs. last t	Yrs.	Months Days		8. Date of Birt (Month, Da 10/16/1	h V. Year) 1919	9. Birth Cou	place (State or Foreign intry) VA
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020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, It a Madical Examinar must be redified at once.	by Funeral		ried 2[X]Married 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:			Yes, specify Cul ☐ Yes 2 ☐ No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	Rican, etc.)		Black, White,	
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	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th	edical C	29a. Certifier (Check only one)	1 Certifying Phy 2 ☐ Medicef Exem	sicien: To the best ner: On the basis of and manner st	f examination:	ige, death and/or inv	occurred at the restigation, in my	time, date and place, opinion, death occur	and due to the red at the time,	cause(s) a date and p	nd manner as salace, and due to	stated. to the cause(s)
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	E		30. Name and add	Iress of person who c	ompleted cause of	death (Item 23a	a) (Type, l	Print)			,-,	20672	
_	2		Paul Po	omilla, M.). 110 Но	spital	Driv	e #310,	Prince Fr	ederick	, MD	20678	
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the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Box 68760. P.O. Š Records. Division of Vital this After death.

5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**X** M 2□ F Director 11-08-1923 218-16-8211 Usual Residence of Deceden the Maryland 10b. County 10c. City, Town or Location 10a. State 27 is marked other than "natural", or items 23e or 28e-f show traumatic event, the Medical Exercitor must be notified at Director MD Somerset Princess Anne 10e. Street and Number 10f. Zip Code 72 hours after death with 31632 Perryhawkin Road 21853 by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 KNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 11 farmer none Maryland 17. Father's Name (First, Middle, Last) Be Minnie Riggin Carl Denston 19a. Informant's Name/Relationship (Type, Print) Elaine Barnes/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Rurial 2 Cremation 3 Removal from State ' 4 Donation 5 Dother (Specify) injury Beechwood Cemetery 22. Name and Address of Facilit 21. Signature of Funeral Service Licensee Hinman Funeral Home _M00295 23. Part 1. Enter the divise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final ocarda **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death Part II. Other significant conditions contributing to meath but not resulting in the underlying cause given in Part I. þ seur Completed 24a. Was an autopsy performed? 2 10 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 22 No 1 TYes 1 Impatient 2 ER/Outpatient 3□ DOA 27. Manuar of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: Natural 5 Pending 1 Tes 2 🗌 No 2 Accident investigation within 24 hours after death To tha Funaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier icai (Check only one) and manner stated 29c. License number 29b. Signature and Doma D 278 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury, MP 21801 100 E. Carroll De NIA/CO 1 homas 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 3 2005 Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - State Registrar 42726 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 0104 29 Denston /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death, **Examiner** REGIONAL Medicul 3A413h4M HICOMICO TENINSULA If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian. Black, White, etc. White 16b. Kind of Business/Industry Poultry/Dairy 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33438 Dublin Road, Princess Anne, MD 21853 20c. Location - City or Town, State 12/31/2004 Princess Anne, MD 111673 Somerset Ave., Princess Anne, MD 21853 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) t 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

Ĺ			State of Maryland / Department of Health 1- State of Maryland / Department of Health Registrer Certificate of Death	and Mental Hyg tas h	iene 9. No 2004	42727
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}	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location	n of Death	4c. County of Deatl	1
			University of Maryland Shock Trauma Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	er 24 Hrs. 8. Date of Birth	Q Rist	nplace (State or Foreign
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	r 28a	Director	10e. Street and Number 10f. Zip Code	10	ng. Citizen of What Co	untry?
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Maryland	2 sho and h Is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num	ber or Rural Route Number,	City or Town, State, Z	ip Code)
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Baltimore,	permit. Pages 1 and Department of Heall Important: If item 2 eny injury or other once.		1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)		20c. Location - City or 1	
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	To the To the comp	Me	29b. Signature and title of certifier 29c. License number	r 29	d. Date signed (Month	, Day, Year)
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K			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING LI. M.D. 111 Penn Street	et Baltimore.	Marvland 2	21201
N.	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 7 2005 Section & Species JAN 0 7 2005		,	
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		1 - For State Registrar	State of Marylar	-	artment o			Reg. No.	2001	1,2728
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Funera Director		Mariner Health 5. Social Security Number 6. Sec	of Bethesd	last birthday)			Irs. 8. Date of Bi (Month, D Mar. 1	rth av. Year)	lontgome 9. Birthp Count 0 Mary	ery lace (State or Foreign yland
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iste be executed whysician and hysician and the burial-transit	Ilcal Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.	quence of):		ONIA				Inferval Between Onset and Death
wrequires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	al death 3[⊒Ectopic pregn: ⊒ Other <i>(specif</i>)			2	23d. Date of delive Month	ory Day Year
law requires that the as been signed by th	Completed by Pt	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	underlying cause	e given in Part I.	1 🗆 24a. Wa	Yes 2	⊒Mo 3 Prob	ne cause of death? ably 4 Unknown psy findings available mpletion of cause of
The ate h	Be Comp	25. Was case referred to medical examiner?	(auto perf 1 ☐ Yes Death (Check only	ormed?	death?	2ETNo
DIVISION OF VICA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: To	1 Yes 2	28a. Date of Injury (Month, Day Year)	28b. Time c lnjury	of 28c.	Injury at Work? 1 ☐ Yes 2 ☐ No		how injury	y occurred d Number or Rura	
o the Hospita thin 24 hours the Funerel	Medical C	29a. Certifier Certifying Phyone) 2 Medical Exam	sician: To the best of my kr iner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	nvestigation, in r	ne time, date and pl my opinion, death o	ace, and due to the ccurred at the time	, date and	and manner as st place, and due to e signed (Month,	the cause(s)
¥ ½ % 8		30. Name and address of person who co	ompleted cause of death (lite	am 23a) (Type	Print)	0057	124	12	1281	04
. S Regis	tate strar	Ruono Boo 31. Date filed (Month, Day, Year) NFC 29 20	32. Fjegistrar's Sigr	nature .	se your		Germai	TOW	n MO	20874

	•	State of Maryland / Department of Health a 1 - For State Registrer Certificate of Death	and Me	ntal Hygien	2004	42729
	16	1. Decedent's Name (First, Middle, Last)	2	Date of Death Month	ay Year	3. Time of Death
Physicia: /Medica		Amanda Lucille Dyson	D	ecember 3		7:35 PM M
Examine		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	f Death	4	c. County of Deat	h
	а	47916 Park Hall Road Park Hall			St. Mary	y's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Months Days Hours	24 Hrs. 8 Min,	Date of Birth (Month, Day, Yea	9. Birt.	hplace (State or Foreign
Director		218–12–9197 1 83 Yrs.				y1and
pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
aryla shov	_	Tod. State Tob. County 100. Only, Town of Education				1 ☐ Yes 2 € No
8e-f	SCTC	Maryland St. Mary's Park Hall				
or 2	בַ	10e. Street and Number 10f. Zip Code		10g. C	Citizen of What Co	untry?
5-0036 72 hours after death with the Maryland neturel; or Items 23e or 28e-f show alsal Examinar must be notified at	Funeral Director	47916 Park Hall Road 20667			nited St	
tems	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Original In Yes, specify Cuban, Mexican,	gin? (Specif i, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Ame Black, White	
36 safte	by	1 ☐ Never Married 2 de Married 1 ☐ Yes 2 de No If Yes, Give 1 ☐ Yes 2 de No Specify: Year or Dates:			Specify: B	1ack
O non le	ם D			100	Vind of Business	la dicata.
21215-0036 dd within 72 hours aft giene. er then "neturel", or ine Medical Exami	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	t of working	160.	Kind of Business/	industry
within within the Mer.	E .	Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker			Own Home	
Hygid Hygid	၁ -	11011101101	r's Name (/	First, Middle, Maide		
and did be of do o	n	Dallas Barnes	D	a Hill	,	
Maryland 2121 12 should be filled within h and Mental Hygiene. 7 is marked other then "it recumatic event, the Mac	0	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	T-11/25-07	A DESCRIPTION OF THE	or Town State 2	7in Code)
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 is marked other then "neturel, or Items 23a or 28e-f show or other treumatic event, the Medical Examinar must be notified at						
Baltimore, Mispermit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other treages.		The Ima Robinson / Daughter 47898 Park Hall Roa 20a. Method of Disposition (Name of	Dat		Location - City or	
nges in it of or o	i	1 ■ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)			•	
Baltimore, Permit. Pages 1 a Department of Hea Importent: If item my njury or othe	-	`4 Donation 5 Other (Specify) Charles Memorial Gdns.				
Bal Permi Depa Impo eny is		21. Signature of Fungers Jacobs Licenses 22. Name and Address of Facility				
2 402 00		Edward N. Brinsfield, Jr. M00052 22955 Hollywood			town, MD	
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):			1825	Approximate Interval Between Onset and Death
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated county.)				y.
8760, cate be executed by sician and the burial-transit	dical Exar	that initiated events resulting in death) Last C. Due to (or as a consequence of): d.	-			
O. Box 6 le death certifi the attending I hed for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)			23d. Date of deli Month	ivery Day Year
cords, P.O. w requires that the de been signed by the should be detached	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco	_	the cause of death?
A rec	Completed	· CHRONIC PENAL FAILURE		24a. Was an	24b. Were au	topsy findings available
Il Rec	Ē	7.77		autopsy performed?	prior to death?	completion of cause of
i: I				1□ Yes 2XN	lo 1 ☐ Yes	XXNo
of Vital F Physicien: The this certificate ral director, pag	Re	examiner?		Check only one)		
Phys at di	0	1 Tes 2 No 1 Inpatient 2 EH/Outpatient 3 DOA 4 Nur	-	d. Describe how inj		city)
ding Ph	0	1 Pending (Month, Day Year) Injury Work?		a. Describe now inj	july occurred	
Division of Vital Records, alor Attending Physicien: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		f. Location (Street a City or Town, Sta		ral Route Number,
	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deat and manner stated.	d place, and th occurred	at the time, date a	nd place, and due	to the cause(s)
To T COM	Σ	29b. Signature and attended certifier 29c. License number			ate signed (Monti	
		→ Mylu MD DSGe	596	1	17.30.0	4
1600				1 RD 1	tarywa	OD MD
Stat Registra	3 11	31. Date filed (Month, Day, Year) JAN 0 4 2005 32. degistrar's Signature				

			1 - For State Registrar	State of Maryla			nt of H te of L			Reg. No.	2004	42730
	Physici /Medic		Decedent's Neme (First, Middle, Last MARIE	AROLYN	EDWAR	DS			2. Date of D Month DEC	Day 23		3. Time of Death 12:30 P M
***	Examin Funeral Director		4a. Facility Name (If not institution, give ATLANTIC GENERAL 5. Social Security Number 6. S 220-12-7597	HOSPITAL	s. last birthday) 78 Yrs.		BER]	LIN If Under 24 Hr Hours Mir	s. 8. Date of B	rth ay, Year)	WORCES 9. Birth Co. MA	
	D.	ector	Usual Residence of Decedent 10a. State 10b. County MARYLAND WORCEST		OCEAN (CITY			,411 0,			10d. Inside City Limits 1 🖾 Yes 2 🗆 No
36	be filed within 72 hours after death with the Maryland tal hygiene. dother than "naturel", or Iteme 23e or 28e-f ehow event, I'm Medical Examinat ratal be notified at	by Funeral Director	10e. Street and Number 626 GULFSTREAM 11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	DR • 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 Ž No If Yes, Give Year or Dates:			edent of Hi ecify Cuba	342 spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)		USA 14. Race - Americal Black, White	rican Indian,
21215-0036	e filed within 72 hour al Hygiene. i other than "naturel vent, ire Medice E	Completed t	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12	fucation	16a. Dece (Give life.	kind of w DO NOT	ork done d use retired	furing most of w	orking		nd of Business/I	Industry
Maryland	should be filed and Mental Hygin marked other imatic event, II	To Be C		WARD E	BROYLES		(20	MATII		CARO	LINE	HEINTZ
	1 and 2 st Heelth and lem 27 is n other treum		19a. Informant's Name/Relationship (WILLIAM H. EDWARD 20a. Method of Disposition	S/HUSBAND	626 Place of Dispo	GULE	STREA	AM DR.,	OCEAN C Date	ITY,		2
Baltimore,	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If Item 27 is marked any Injury or other treumstic e once.		1 🔀 Burial 2 Cremation 3 C 4 Donation 5 Other (Specification of Funeral Service Licer	1)	2	ILLE ETERY 2. Name a	VETEI	RAN 12/	29/04	-		, MARYLAND
E.	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to focas a conse	ath. Do not en	ter the mo	de of dying		-		LLE, DE	Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physicien and id for use as the burial-transit	edical Examiner	if ally, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse								
P.O. Box (that the death certificate to the by the attending physic detached for use as the to the the the the the the the the the the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	ital death 3[⊒Ectopic	pregnancy specify)			2	3d. Date of deli Month	very Day Year
Ś	w requires that the been signed by th should be detache	by	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	inderlying	cause give	en in Part I.				the cause of death?
tal Record	The law ate has t page 2 s	e Completed	25. Was case referred to predical					26 Place of D	24a. Wa auto pen 1 Yes	ormed? 2 □ No		topsy findings available completion of ause of
f Vital	ys dis	To Be	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 🗆 🗅	Othe	The state of the s	Home 5 🗆 Res		☐Other (Spec	cify)
Division of	ding After fune	ertification:	27. Manns Death 1 atural 5 Pending investigation		28b. Time of Injury	of M	28c. Injury Work 1 🗆 `	rat i? Yes 2 □ No	28d. Describe	how injury	occurred /	
Divi	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the I	O	3 Suicide 6 Could not b determined	building, etc. (Spec	cify)				City or To	wn, State,		ral Route Number,
	the Hos	edical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Example 1	ysician: To the best of my kinder: On the basis of examinand manner stated.	nation and/or in	n occurre vestigatio	d at the tim n, in my of	oinion, death occ	ce, and due to the curred at the time	date and	and manner as place, and due	to the cause(s)
)	To the within To the Compl	Me	29b. Signature and title of certifier	MD		1	D53				signed (Month)	
	im		01000	completed cause of death (Its	em 23a) (Type	Print) Itca	Hhn	ag TV	Berlin	W	218/1	1
F	Sta Regist		31. Date filed (Maria Day, Year) 20	04 32. Pegistrar's Sig	nature	Δp	acks	0				

Edwards, Marie C 5/4/1126 DOD 13/13/14 1030

		•	For State of Maryland / De Registrar	ertificate of Death	wental Hy	Reg. No.	4 42731
	Physici		. Decedent's Name (First, Middle, Last) James Larry Era		2. Date of De Month	Day Ye	
	/Medic Examin		a. Facility Name (If not institution, give street and number) Yen 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	4b. City, Town, or Location of Deat		4c. County of D)eath
	Funeral Director		. Social Security Number 6. Sex 1 M M 2 F 7. Age (In yrs. last birthda) 68 Yrs		8. Date of Bi		Birthplace (State or Foreign Country) Delaware
0	show		Jsual Residence of Decedent 0a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
3	vith the Maryla or 28a-f shove	ector	Maryland Wicomico Salisb			40-022	1 X Yes 2 No
1	th with the 23e or 2	al Dire	0e. Street and Number 5827 Bay Street	10f. Zip Code 21801		10g. Citizen of What	Country?
2-20	after dea	by Funeral Director	1. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates AirForce	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No o Rican, etc.)	14. Race - A Black, V Specify:	American Indian, Vhite, etc. White
722-	72 hours "naturel',	Completed	15. Decedent's Education (Specify only highest grade completed) (G. (G.	cedent's Usual Occupation we kind of work done during most of wo by DO NOT use retired)	rking	16b. Kind of Busine	ess/Industry
212	2 should be filed within 72 he and Mantal Hygiene. Is marked other than "natu	dwo	Elementary/Secondary (0-12) College (1-40f 5+)	ine Operator		Dresser I	ndustries
nd br	be filed tal Hyg d othe event,	Be	7. Father's Name (First, Middle, Last)			a, Maiden Surname)	
Raryland	should be and Mental Is marked c	To	James Nelson Era 19a. Informant's Name/Relationship (Type, Print) 19b. Mi	Anna Lilling Address (Street and Number or Ri	Ouise N:		te. Zip Code)
	alman 27 Isr			Madison St., Sal			
Baltimore	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other treat		20a. Method of Disposition 20b. Place of Dis	position (Name of rematory or other place)	Date 29/04	20c. Location - City Hurlock,	or Town, State
Balti	permit. Departn Imports any inju		The Hollo	501 Snow Hill Rd	Salich	1777 MD 21	Association 804
	Physician	W.	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on bach line. Immediate Cause (Final disease or condition	enter the mode of dying, such as cardia	or respiratory a	arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
	بيد	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
_	xecuted and Il-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	\$			
68760,	icate be executed physician and s the burial-transit	edical E	d				
Division of Vital Records, P.O. Box 68	E O a	by Physician/Med		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of Month	delivery Day Year
rds, P	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.		/	e to the cause of death? Probably 4 Dunknown
l Reco	sicien: The law re certificate has bee irector, page 2 sho	Completed			24a. Was auto perf 1 🗆 Yes	ppsy prior deatl	e autopsy findings available to completion of cause of h? Yes 2 \sum No
Vita	ysicien: The lis certificate hadirector, page	Be	25. Was case referred to medical examiner?	Othor	ath (Check only		
to	g Phys or this oral dir	n: To	27. Manner of Death 28a. Date of Injury 28b. Tim	of 28c. Injury at		idence 6 Other (5 how injury occurred	Specify)
sion	ending eath. or: Afte	catlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
DIVI	of or Att	Certification:	3 Suicide 4 Homicide Gould not be determined A Homicide Gould not be determined 28e. Place of Injury · At home, farm, building, etc. (Specify)	street, factory, office		(Street and Number o. own, State)	r Rural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, did not only and manner stated.	investigation, in my opinion, death occi	urred at the time	, date and place, and	due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Tyle Completed Cause of Death (Item 23a) (Tyle Completed Cause of death (Item 23a) (Tyle Cause of Death (Item 2	29c. License number D 5 79 5 &	2	29d. Date signed (M	onth, Day, Year) 3 1200 4
	DIVA		30. Name and address of person who completed cause of death (Item 23a) (Ty Bubulal Dm. 106 Milford ST	# 504B , Salish	ery. V	10 2/80	4
	Sta Regist		31. Date filed (Month, Day, Year) 32. Redistrar's Signature	of sporked			

			State of Man	•			Mental Hyg	iene	
			1. Decedent's Name (First, Middle, Last)	Cei	rtificate of l	Jeam	2. Date of Deat	g. No	1, 2732
	Physici		Maria Eugenia Moya Espinoz	a			Month	Day Year 27, 2004	12:05 PM
	/Medio Examin		4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or	Location of Dea		4c. County of Dea	
		Ϋ.	250 B Hill Top Lane #207		Annap	olis		Anne Aru	nde1
	Funeral		104 28 =	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours Min	n. (Month, Day,		rthplace (State or Foreign country)
	Director	ŀ	764-10-9409 1니M 2업투 50	4 115.			April 9,	1950 E	l Salvador
	yland			C. City, Town or Lo	ocation				10d. Inside City Limits
	e Mar	ctor	Md. Anne Arundel		Annapo	lis			1∭ Yes 2 No
	or 28	Dire	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	ountry?
	a 23e	Funeral Director	250 B Hill Top Lane #207	wie 11 C 1 12	21403		(Const. Vos es No	El Salva	
	ter de	Fun	11. Marital Status 12. Was Decedent Eve Armed Forcas? 1 ☐ Never Married 2 Amarried 12. Was Decedent Eve Armed Forcas?				(Specify Yes or No- erto Rican, etc.)	Black, Wh	
036	al', or	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		¥⊡Yes 2□No	SpecifySa1	vadoran	Specify: W	nite
21215-0036	within 72 hours after death with the Maryland ane . than "natural", or itama 23a or 28a-f show ita Madical Eraminar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done	during most of w	rorking	16b. Kind of Busines	s/Industry
121	withIn ne. han "	mpi	Elementary/Secondary (0-12) College (1-4or 5+)		ousekeepe	•		Self-Emp	loved
	Hygie Hygie other ant, II		17. Father's Name (First, Middle, Last)	11		18 Mother's N	ame (First, Middle, M	faiden Sumame)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygjene. Important: if item 27 is marked other than "natural", or Itama 23a or 28a-1 show important: if item 27 is marked other than "natural", or Itama 23a or 28a-1 show any high pury or other traumatic event, the Madical Eseminar must be notified at any injury or other traumatic event, the Madical Eseminar must be notified at any once.	To Be	Pedro Moya			Maria Julia	Espinoza		
lary	and N	Γ,	19a. Informant's Name/Relationship (Type, Print)	19b. Mailii 250	ng Address (Street	and Number or i	Rural Route Number,	City or Town, State,	Zip Code)
	1 and 2 Health tem 27		Jose Coto Fuentes (Husband)	Ann	apolis, M	lary land	, 21403		
Baltimore,	Pages 1 nent of H int: If ite iry or ot		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State		natory or other plac			20c. Location - City o	
Ξ	artmer artmer ortant injury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral,Service Licensee	Family Ce	-	1	05-05 1 H. Bacon 1	El Salvado Funeral Ho	
Ba	permit. Departr Imports any Inju		Wanda C. Bacon Co				W. Wash.,		
	1		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not en	er the mode of dyin	g, such as cardi	ac or respiratory arre	st,	Approximate Interval Between
	Physician	(0.3)	Immediate Cause (Final disease or condition	Co Co	anier				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a c	onsequence of):					Year
		<u>-</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a c	onsequence of):					
	uted d ansit	Examiner	cause. Enter Underlying Cause Disease of Injury						1
oʻ	execul an and rial-trar	Exa	resulting in death) Last C. Due to (or as a c	onsequence of):					
8760,	The law requires that the death certificate be executed tae been signed by the attending physician and oage 2 should be detached for use as the burial-transit	dicai	d						
9	ertific ding pl	Mec	IF FEMALE: 23c. If yes, outcome of						
Box	leath certific attending pl	Physician/Me	in the past 12 months?	∃Fetal death 3 [Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
P.O.	res that the de signed by the a be detached f	nysic	1 Yes 2 No 4 Pregnant at time 9 Unknown 9 Unknown						
	s that med b	by PI	Part II. Other significant conditions contributing to death but r	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
ords	w require been sig should b	ed t					1 □ Ye	s 2⊡No 3□F	robably 4 Unknown
Records,	has be	Completed					24a. Was ar	/ prior to	utopsy findings available completion of cause of
<u>=</u>	: The	Con					perform 1 ☐ Yes 2		s 2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:		Oth)		eath (Check only one		
of	Phys er this eral di	. To	1 Yes 2 No 1 Inpatient 27. Manner of Death 1 Natural 5 Pending (Month, Day Y.	2 ER/Outpatier 28b. Time o	f 28c. Injury	at	Home 5 Reside		ecify)
ion	Attending F death. ctor: After y the funera	atior	1 □Natural 5 □ Pending (Month, Day Y. 2 □ Accident investigation	ear) Injury	Worl	k? Yes 2. □No			
Division of	I or Attending after death. Director: After I in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (- At home, farm, sti	eet, factory, office		28f. Location (Str City or Town	eet and Number or F , State)	ural Route Number,
	urs aft								
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funaral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physician: To the best of n (Check only one) and manner states	amination and/or in	h occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To th Within To th compl	Me	29b. Signature and title of certifier		29c. Licenso	number		d. Date signed (Mon	
)			1/2 3/4 NO		Doc	5(30)		lecember	292004 MO 2199
R	(3)		30. Name and address of person who completed cause of deat	(Item 23a) (Type,	Print)	- (v.	Dr 300	Anna 1	× 110 1102
	Sta	te.		900 Bes	tigate Y	040,30	1110) 00	7 VINIA O	mo ary
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Reg. No. CUUL Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 1003 cember 28 2004 Catherine Fields /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wiconece Medical Isbur Center Peninsula Kegional 8. Date of Birth (Month, Day, Year) April 23, 1919 If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 □ X 85 Director 212-40-7792 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County 10a. State 28e-f show other traumatic event, the Madical Examiner hast be notified at 1 X Yes 2 No Director MD Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 607 S. Division St. or items 23a 21826 U.S. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates: þ 3 Nidowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry atherine Fields and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Laborer 8th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental P John Johnson Florrie Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Decartment of Health and Important: If item 27 Is n any injury or other treun John H. Fields/son 407 Viewfield Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Green Acres Mem Park 1/3/2005 21. Signature of Funeral Society Licen 22. Name and Address of Facility Lewis N. Watson Funeral Home 23a. Part. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21801 Approximate Interval Between Onset and Death Immediate Cause (Final Physician 15 min myscardial disease or condition resulting in death) marchin /Medical Due to (or as a consequence of): **Examiner** 2 Mins arlen Cornein Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Weknown Cerebrovescuting Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? aduri 2 □No 1 ☐ Yes 2 ☐ No angestire 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 35 BOA 1 Xes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 - Natural

Division of Vital Records, al or Attending a after death.

within 24 hours a To the Funerel C

3

State Registrar 2 Accident

3 Suicide

29a. Certifier (Check only one)

KUDNEY

A.

31. Date filed (Month, Day, Year)

4 Homicide

29b. Signature and title of certifier a Wernich

29c. License number 15384

SALISBURY

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 04

21804

MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1346 S. DIVISION ST.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

JAN 03 2005

VVENRICH

6 Could not be

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		Decedent's Name (First, Middle, L.)	ast)	97.04			2. Date of De	ath	3. Time of Death
Physic /Medi		Rebecca	Α.		Fisher		Month Nece.	22 20	004 1030 M
Exami	ner	4a. Facility Name (If not institution, 9	ive street and number)			or Location of Death		4c. County of	Death PoM/Co
Funeral Director		212-56-2004		e (In yrs. last birth	Months Days		8. Date of Bir (Month, Da 09-15-	y, Y.ear)	D. Birthplace (State or Foreign Country) Delaware
show		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
8e-1 s	Director	MD Somer	set	Princ	ess Anne				1 ☐ Yes 🎉 No
with tage of 2	Dir	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	
death ms 23	Funeral	26980 Mt. Verno	12. Was Decedent		21853 13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spe	ecify Yes or No	USA 14. Race -	American Indian,
permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28e-1 show any injury or other traumatic event, it is Medical Exerciting in still be inclined at ance.	by Fur	1 Never Married AM Married	If Yes, Give		If Yes, specify Cub		Rican, etc.)	Black, Specify:	White, etc.
turel.	q pa	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	162 [Decedent's Usual Occur	nation		16b. Kind of Busi	White
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be file ta! Hy d othe event,	Be	17. Father's Name (First, Middle, Las	st)	-		18. Mother's Name	e (First, Middle	, Maiden Sumame)	
Men I Men narke	၉	Paul Elliott	or Did			Anna Mae	-		
d 2 st d 2 st th and 17 is n traun		19a. Informant's Name/Relationship			Mailing Address (Street				
1 and 1 Health tem 27		Charles Fisher/H 20a. Method of Disposition	usband	26 20b. Place of E	980 Mt. Ver Disposition (Name of	rnon_Road_	Prince	20c. Location - Ci	(II) 21853 ty or Town, State
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permit Deparm Deparm Imporial any inu		21. Signature of Funeral Service Lic	• •	ASbury	22. Name and Addre Hinman Fur	ery 12/2	//2004	mt. verno	on, Marylard
		Mas XXXX	XXXXI. M	00295	11673 Some	erset Aven	ue. Pri	incess An	ne, MD 21853
	1	23a. Part1. Erts the isease, or co shock, or hear failure. List on	mplications hat caused by one was on each to	d the death. Do no	t enter the mode of dyi	ng, such as cardiac o	or respiratory a	rrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	-a 00100	anduc	d info	nction	٥		Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a consequence of):				Chronic
HELL	- G	Sequentially list conditions,	b. One to (or as	a nonsecuence of	b:				
uted d ansit	Examiner	Sequentially list conditions, in any, leading to himself at cause. Enter Underlying Cause, (Disease or injury that initiated events	. 1	Millery	000010	1			
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ate be hysici	licai		d						
leath certificate be attending physic	Physician/Medic	IF FEMALE:	20- 16						
attenc for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у		23d. Date of Month	,
y the di	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	t time or death	3 Girler (specify)				
Attending Physicien: The law requires that the death certificate redath. ector: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	þ	Part II. Other significant conditions	contributing to death b	out not resulting in t	he underlying cause giv	ven in Part I.	23e. Did t	-	ute to the cause of death?
w require s been sig	ompieted	MIDERLI	orden	0			24a. Was		re autopsy findings available
The lav	omp.	tipocici	6				autor perfo	rmed? dea	or to completion of cause of hth? I Yes 2 No
ilcien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	1			26. Place of Death			
Physic this o	P	1 Yes 2 No	Hospital: 1 Inpatie					dence 6 Other	(Specify)
ding P. After funer	Certification:	27. Manner of Death Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da	y Year) 28b. Tin y Year) Inji	ary Wo	ryat rk? [Yes 2 □ No	28a. Describe i	now injury occurred	
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rs afte	Cert	4 nomicide	building, et	c. (Specify)			City or To		
To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate h completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying I 2 Medicel Expone)	Physicien: To the best aminer: On the basis o and manner st	t examination and/	death occurred at the ti or investigation, in my o	me, date and place, a opinion, death occurr	and due to the ed at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)
To the Complex complex	Σ	29b. Signature and title of certifier)ν	no	29c. Licens	-		29d. Date signed (I	Month, Day, Year)
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		Amy Johnson, M.D				oko Cit	MD 210	5 1	
St	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature		oke city,	TID 218	J1	
Regist	rar	DEC 2 9	2004	eve &	Locale				

			1 - For State Registrar	State of Ma		Depa		lealth and M	lental Hygi	ene	4 42735
	Physici /Medio Examin	al	Decedent's Name (First, Middle, L Henrietta 4a. Facility Name (If not institution, g 1809 Iverson	Hatter Fowl	er		-	r Location of Death	2. Date of Death Month December	25 20 4c. County of	
	Funeral Director		5. Social Security Number 577-22-7657 Usual Residence of Decedent	Sex 7. Age 1	91	virthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1) June 16,		Birthplace (State or Foreign Country) Wash., DC
	ith the Maryland or 28a-f ahow	Director	10a. State 10b. County Maryland Prince 10e. Street and Number	e George's	10c. City, To	wn or Lo	Oxon Hi	i11	10	g. Citizen of Wha	10d. Inside City Limits 1 🛣 Yes 2 🗆 No at Country?
396	toges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f ahow or other traumatic event, the Macheal Examinater ust be motified at	by Funeral [1809 Iverson 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces?		1	Vas Decedent of H Yes, specify Cuba	20745 dispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race -	ed States American Indian, White, etc. African American
21215-00	e filed within 72 hou al Hygiene. I other than "natural vent, Ire M. d E.! E.	Completed t	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education		(Give	ent's Usual Occup kind of work done OO NOT use retired Teach	during most of work d)	ing 10	6b. Kind of Busin	
Maryland 21215-0036	2 should be filed and Mental Hygid is marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, La Thori 19a. Informant's Name/Relationship	mas Hatter	19	b. Mailin	g Address (Street	18. Mother's Name		ta Rhon	e
Baltimore, Ma	Pages 1 and 2 ant of Health a nt: If item 27 is y or other trai		Henrietta F. Ca 20a. Mathod of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific Properties)	☐Removal from State	20b. Place cemet			on St., Os cery 1/3/			745 ty or Town, State
Baltin	permit. Pages 1 Department of H Important: If ite any Injury or ot		21. Signature of Furieral Service Lic	Slugar.	III	22	Name and Addre	ss of Facility St enning Rd.	ewart Fu , N.E. W	neral Ho ash., Do	ome C 20019
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Osuse (Final disease or condition resulting in death)	a Alz	heimer a consequence	s D		ig, such as cardiac o	or respiratory arres		Approximate Interval Batween Onset and Death 10 Years
760,	ate be executed nysician and he burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	umonia a consequence ral Ulc a consequence	cer					3-4 Weeks 10 Weeks
О. Вох 68	death certifica e attending pl d for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)	,		23d. Date o	
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Division of Vi	tending Physicath.	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	be 200 Place of Inju	y Year) 28b.	Time of Injury	28c. Injur Wor M 1	er: 4 □ Nursing Ho y at k? Yes 2 □ No	me 52 Residen 28d. Describe how	ce 6 Other (Specify) or Rural Route Number,
OIV	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical Certif	4 Homicide determine		c. (Specify)				City or Town,	State)	
0	To the H within 24 To the F complete	Medi	29b. Signature anguitie of certified	M T	9M	16	29c. Licens				Month, Day, Year)
	Sta		30. Name and address of person when Robert T. D. 31. Date filed (Month, Day, Year) DEC 3 0 20	ibble, M.D.		Irvi	ng St., N	N.W. #4200	Wash.,	DC 200	10
	Registr	ar	חבר אים בה	- Dieve		6	a				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:20 P M 12 26 2004 Ethelyne Warren Fowler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Months Hours 1 ☐ M 2 🔀 F Yrs. Norfolk, VA. 82 0305 Director 577-28-7009 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23a or 28a-f show the Medical Exerciper ... ust by notified at 1X Yes 2 No DC Washington Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 5107 New Hampshire Avenue N.W. 20011 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 4 yrs. Administrative Clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 Ie marked any injury or other treumatic evone. John W. Warren Cora L. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20895 19a. Informant's Name/Relationship (Type, Print) 3333 University Blvd. West #412 Kensington, MD. Christine M. Knight/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Harmony Memorial PK. 12-30-04 Landover, MD. 22. Name and Address of Facility MArshall's Funeral Home 21. Signature of Funeral Service Licensee Pmaishall 4217 9th. St. N.W. Washington, D.C. 20011 23a. Part / Into the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia /Medical Due to (or as a consequence of): Examiner Bacterial Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Completed by Physician/Medical as the IF FEMALE: US8 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 17 No 1 Yes 1 Tyes 2 🔀 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🔀 No 1X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification; To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) itetely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number exter (C. 12-27-04 D 26765

31. Date filed (Month, Day, Year) 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



-		1 - For State Registrar AMEND#3perMD1,	///OS,BWW,PDCO C	epartment of Health and Certificate of Death	Reg	. No.
Physic /Medi	cal	1. Decedent's Name (First, Middle, Lasi Bernard 4a. Facility Name (If not institution, give	, tortner	4b. City, Town, or Location of De-		Day Year 2. County of Death
Examir Funeral	ner	HOWARD COUNTY GED 5. Social Security Number 6. Se	NERAL HOSPITAL	Columbia (ay) If Under 1 Year If Under 24 Hi	s. 8. Date of Birth	Howard County
Director		578 28 9570	78 Yrs		i. (inditin, day)	1926 Washington, D.
anyland show	-	10a. State 10b. County	10c. City, Town o			10d. Inside City Limits 1 □ Yes 🔏 🖟 No
the M 28a-f notifie	recto	Maryland Howar 10e. Street and Number	d Highla	and 10f. Zip Code	100	. Citizen of What Country?
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re, Maryland 21215-UU36 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23a or 28a-1 show other traumatic event, the Medical Eventrat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 □ No. If Yes, Give Navy .	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes ※ No Specify:	Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
5-UU 72 hour neturel	eted b	15. Decedent's Ed (Specify only highest grad	ucation 16a. D	ecedent's Usual Occupation give kind of work done during most of w	orking 16	b. Kind of Business/Industry
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Baltimore, Mispermit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □	20b. Place of D cemetery,	isposition (Name of crematory or other place)		000 00 000
it. Pa artmen artant: injury		*4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Set is Lice		12/ Name and Address of Facility 7	30/2004 Si	uitland, Maryland
Department of the control of the con		tour 1	Curon _	22. Name and Address of Facility H 11800 New Hampshi		di Funeral Home ver Spring, MD 20904
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58 / 50, ficate be axecul physician and s the burial-trar	dical Exa	resulting in death) Last	Due to (or as a consequence of) d.	:		
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- o - c	Completed				24a. Was an autopsy performe	
Of VITAL Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Heavital.	O#	eath (Check only one)	
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IVISI or Atten frer deat irrector: or by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined			28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
Hospital of the filled is stelly filled is	Medical C		ysician: To the best of my knowledge, of iner: On the basis of examination and/of and manner stated.			
To the I within 2. To the I complet	Me	29b. Signature and title of certifier		29c. License number		. Date signed (Month, Day, Year)
10		101		D43725		12/27/04
		TARIQ MALT	completed cause of death (Item 23a) (Ty	Back River	Neclo	12/27/04 MD 21221 Rd Baltimon
St Regist	ate rar	31. Date filed (Month, Day, Year) DEC 2 9 20	32. Registrar's Signature	Sparks		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** DORIS ELIZABETH FRINGER DEC 29 2004 5:25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CARROLL HOSPITAL CENTER CARROLL WESTMINSTER Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🖾 F 76 Yrs. 212-32-4019 10/18/1928 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Madical Exacitratinual be notified at 1XYes 2 ☐ No Director CARROLL WESTMINSTER MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code MAIN ST., 21157 USA APT. 79 WEST Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) other than Elementary/Secondary (0-12) HOUSE KEEPER HOUSE CLEANING 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **EVA** YOWELL **JOHNSON** marked HERBERT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u>s</u> permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. GEORGE N. FRINGER -HUSBAND 79 W. MAIN ST., APT.C, WESTMINSTER, MD.21157 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State WESTMINSTER CEMETERY 12/31/04 WESTMINSTER, MD. Other (Specify) 4 Donation uner Se vic Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart tailure. List Immediate Cause (Final **Physician** 1-sporesturn heumen disease or condition resulting in death) /Medical Due to (as a consequence of): **Examiner** Sequentially list conditions, I arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-transit Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2□ No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes Inpatient 2 🗌 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification:

requires that the death certificate be

the Maryland

2 should be f and Mental I

FRINCER

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: 24 hours a within 24 ho To the Fun completely i MSI

s after death.

DHMH 17 Rev 1/2001

State Registrar

Medical

1 Natural

2 Accident

3 Suicide

29a Certifier

4 Homicide

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

determined

30. Name and address of person who completed cause of death

2 Medical Examiner: On the basis of and manner state

31. Date filed (Month, Day, Year) 32. Registrar's Signature DÉC 3 0

Certifying Physician: To the best of my knowledge, death occurre

em 23a) From Print)

1 Tyes

29c. License number

2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

the time, date and place, and due to the cause(s) and manner as stated

in my opinion, death occurred at the time, date and place, and due to the cause(s)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

examination and/or investig

State of Maryland / Department of Health and Mental Hygien [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Jeanette Fenwick December 24, 2004 16:15 P Kyaira /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** St. Mary's Hospital Leonardtown Mary's Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 F Yrs Director Dec. 24, 2004 Maryland 6 None Usual Residence of Decedent the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show other traumatic avant, the Medical Exeminer must be notified at 1@Yes 2□No Directo Maryland | St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Itams 23a 20650 22872 Lawrence Avenue United States by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No 14. Race · American Indian. Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. d 2 should be filed within 7 in and Mental Hygiene.
7 is markad other than "r Elementary/Secondary (0-12) College (1-4or 5+) 0 None None 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Patrick Wayne Fenwick Sheneka Renee Banks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an itam 27 ia P.O. Box 2448, Leonardtown, Maryland 20650 Sheneka R. Banks / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of I permit. Pages Department of I Important: If its any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 12-30-2004 Leonardtown, Maryland Charles Memorial 22. Name and Address of Facility Brinsfield Funeral P.A. of Funeral Service Edward N. Brinstield, Jr. 22955 Hollywood Road, Leonardtown, MD 20650-0279 M00052 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiopulmonary Arrest - Neonatal /Medical Due to (or as a consequence of): **Examiner** Extreme Prematurity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the burial-transit Preterm Delivery Due to (or as a consequence of) ed by the attending physician detached for use as the buria P.O. Box 68760 Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Twin "A" of twin pregnancy at 21 6/7 weeks 1 ☐ Yes 2 ■ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ₺ No 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 2 1 Tyes 2 10 No Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide To the Hospital o within 24 hours aft To the Funaral Di 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12/24/04 D0055831 no who completed cause of death (Item 23a) (Type, Print) ress of person Lisa Polko, 23000 Moakley Street, Suite 201, Leonardtown, Maryland 20650 M.D31. Date filed (Month, Day, Year) Registrar's Signature 32 State JAN 0 7 2005 Registrar

Amended	Items 2 & 3 per M.D. Please Type or Print in Bl	12/30/2004 Carroll Cou ack Indelible Ink. Ensure Al	inty, wj1 I Copies Are Legible.
	State of Maryland	/ Department of Health and M	ental Hygiene

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		Examin	er	4a. Facility Name (give stree		nber)	719V	-	4b. City,		r Location	of Death		4	c. County of	Death	110	
		Funeral		5. Social Security N	1 1	6. Sex			In yrs. last		If Unde	1 Year		r 24 Hrs.	8 Date of Bir	rth	J. 9	. Birthp	ace (State or Foreign	1
		Director		217-28-21		1 🗆 M	2 \(\) F		79	Yrs.	MOHUIS	Days	Tiours	IVIII I.	Jan. 2	2,	1925	Má	ryland	
1		show		Usual Residence of 10a. State	10b. County			1	Oc. City, To	wn or Loca	ation							1	Od. Inside City Limits	_
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>	ore,	of Hea of Hea item		20a. Method of Dis	*	2 DD			20b. Place ceme	of Disposit	tion (Na	me of other place	ce)		Date	20c. l	ocation - Ci	ty or To	wn, State	_
MARY	Baltimore,	Page ment ant: If		`4 ☐ Donation	Cremation 5 Other (Sp		oval from	State	All C	ounty	Cre	emati	on		29,2004		kesvi			
M	Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-1 show amy injury or other traumatic avent, the Medical Examinet ruust be invitified at Once.		21. Sign of Fu	Jarine L	icensee	X	rz	len			oa dw	ss of Faci vay		artzler on Brid					
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	, P.O.	res that t signed by be detac	by Ph	Part II. Other signi	ficant conditio	ns contribu	uting to de	eath but r	not resulting	g in the und	derlying o	ause give	en in Part	1.	23e. Did 1	tobacco	use contrib	ite to th	e cause of death?	
	rds	w requires been sign should be													1 🗆	Yes 2	2 □ No 3	Proba	ably 4 Dunknown	
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	Division of Vital Records,	or Att	Certification;	3 Suicide 4 Homicide	dotomi			of Injury ng, etc. (- At home, (Specify)	farm, stree	et, factor	y, office		:	28f. Location (City or To			or Rurai	Route Number,	
	luni	To the Hospital or Attandin within 24 hours after death. To the Funeral Diractor: Aft completely filled in by the fur	al Ce	29a. Certifier	1 ☑ Certifying															-
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4		with To	Σ	29b. Signature and	I title of certifier	Joi	im(sof.	elm	0	29		e number	9943	3		ate signed (27, 2001	
		KL		30. Name and add	ress of person	who comple	eted caus	of deal	th (Item 23:	a) (Tvon. Pi	rint)						11 52	-7	-11-301	_
	_	MILLI		Jours C	A 2021,1							Suit	2 30	V	rsstm,	inst	er	170	21157	
		Sta Regist		31. Date filed (Mor	nth, Day, Year) DEC 3	0 20		100	Signature	K	Ann.	٠. م								

			1 - For Stata Ragistrar	State of Mar		artment of F		Mental Hygier	0001	b 27b 1
	Physici /Medio Examir	al	DORIS BROOKE GONG 4a. Facility Name (If not institution, give s			4b. City. Town. o	r Location of Death	DECEMBER	26,2004 26. County of Death	3. Time of Death 10:30A
	Funeral	er	1013 MAYO ROAD 5. Social Security Number 6. Sex	7 Age /	(In yrs. last birthday)	EDGEWATI]	NNE ARUNI	
	Director		261 32 2543 Usual Residence of Decedent 10a. State 10b. County	M 2XF	77 Yrs.		Hours Mill.	JAN. 29, 19	27 FLOF	ATDA 10d. Inside City Limits
	h the Maryl or 28s-f sho e notified a	Director	MARYLAND ANNE ARUNI 10e. Street and Number	DEL	EDGEWATER	10f. Zip Code		10g. (Citizen of What Cou	1 ☐ Yes 2 X No
36	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show officel Exercites triust be notified at	by Funeral D	1013 MAYO ROAD 11. Marital Status 1 □ Never Married 2 □ Married 3XXWidowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1		21037 Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert Specify:		TED STATE 14. Race - Amer Black, White Specify:	can Indian, , etc.
21215-0036	swithin 72 hour piene. r than "natural the Medical Ex	Completed t	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation a completed) College (1-4or 5+)	(Give	DO NOT use retired	during most of wor d)	king	Kind of Business/II	ndustry
Maryland 21	be filed tal Hyg d othe evant,	To Be Co	12 17. Father's Name (First, Middle, Last) DANIEL L. BROOKE	0	POSTA	L SERVICE		U. ne (First, Middle, Maid NELLEN	S. POSTAL en Sumame)	SERVICE
	1 and 2 s Health ar am 27 is thar trau		19a. Informant's Name/Relationship (Type JAMES LEE GONCE 20a. Method of Disposition	oe, Print) (SON)	1013 1 20b. Place of Dispo	MAYO ROAL sition (Name of	EDGEWA		y or Town, State, Zi	
Baltimore,	t. Page rtment o rtant: If njury or		1 Burial 2 Termation 3 Re '4 Donation 5 Other (Specify) 21. Signature of Termatal Inc. Ice Legon	emoval from State	cemetery, cren KALAS CRI	natory`or other plac EMATORY	12-2		GEWATER,M	D.
8	permi Depa Impo any le sany le		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ie cause on each line.	ne death. Do not ente	er the mode of dyin	ng, such as cardiac	ND ROAD ED or respiratory arrest,	GEWATER,M	D. 21037 Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	Due to (or as a	tons (q	r (9)	16 6			non
8760,	death certificate be executed e attending physician and d for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or Injury that initiated events resulting in death) Last	Due to (or as a	consequence of): consequence of):					
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rds, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions con	tributing to death but	not resulting in the ur	nderlying cause giv	en in Part I.		o use contribute to	he cause of death? bably 4 □Unknown
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Division	or Attan after deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home, farm, str (Specify)		185 2 1140	28f. Location (Street City or Town, Sta	and Number or Run ate)	al Route Number,
	the Hospital hin 24 hours ths Funaral mpletely filled	Medical ((Check only 2 Medical Examin one)	ner: On the basis of each and manner state	xamination and/or inv id.	estigation, in my o	pinion, death occu	and due to the cause red at the time, date a	nd place, and due t	o the cause(s)
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	Physici	an .	Decedent's Name (First, Middle, Last								2. Date of De. Month	Day		3. Time of Death
	/Media		MARY LOUISE LONG				45 635 3			(D 4h	12	30	2004 County of Deat	0435AM
	Examir	ier	4a. Facility Name (If not institution, give	street and numb	er)				Location of BURY	or Death		40.	WICOM	
	* 5		798 TERRIE COURT 5. Social Security Number 6. Se	x 7.	Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Birl (Month, Da	th	9. Birt	thplace (State or Foreign
	Funeral Director		579-20-2176	☐ M 21 XF	83	Yrs.	Months	Days	Hours	Min.	(Month, Da 01-24-	19. Year) 1921	l Co	TLAND, MD.
		1	Usual Residence of Decedent											
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	ltern Item	nu.	11. Marital Status 1 Never Married 2 Married	Armed Force	es?	.3.	If Yes, spec	ify Cubar	n, Mexican	i, Puerto	ecify Yes or No Rican, etc.)		Black, Whit	
336	urs af	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	Λ		1 ☐ Yes 2	2⊠ No	Specify:				Specify: W	HITE
21215-0036	2 hou	ted	15. Decedent's Ed	ucation		16a. Dece	dent's Usua	Occupa	tion	t of work	ina	16b. Kir	nd of Business	/Industry
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yla	should be to not Mental I marked o	ပ္	J. BRICE LONG	5 : 4		405 14-75		(0)			WINDSOR al Route Numbe		Town Ctata	Zin Code)
Maryland	~ ~ ~		19a. Informant's Name/Relationship (7 H. LOUIS HORNER, J.				3				ALISBUR			
	of Health of Health Item 27		20a. Method of Disposition	50N	20b. F	Place of Dispo	osition (Narr	ne of			ALISBUK Date		cation - City or	
Baltimore,	nt of it		1∑ Burial 2 ☐ Cremation 3 ☐		110	cemetery, crei	-			01 0	2 2005			
Ē	permit. Pages Department of Important: If It any injury or o		*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen:		PAR	RSONS (NDS FUN			MARYLAND
Ba	permit. Departr Importa any inju		Mulista hu	1/4/11	us.									ND 21804
	Physician /Medical Examiner		23a. Pm1. Enter the disease, or softe sock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a		ONIC							MSE	Approximate Interval Between Onset and Death
8760,	eath certificate be executed attending physicien and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq									
.O. Box 68	D 0 D	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ∏ Feta ntattime of d	il death 3	⊒Ectopic pr ⊒ Other <i>(sp</i>					2	3d. Date of de Month	livery Day Year
<u>ر</u>	s that the ned by th e detache	by PI	Part II. Other significant conditions co	ontributing to deal	th but not res	sulting in the u	ınderlying c	ause give	n in Part I		23e. Did t	obacco u	se contribute to	the cause of death?
rds	w requires been sign should be		Coronvey	artee	J- E	Juson	ف				1/2	Yes 2	□No 3□Pr	robably 4 Unknown
Records,	aw is b	Completed	O		7						24a. Was		24b. Were at	utopsy findings available completion of cause of
Ä		E										ormed2	death? 1 ☐ Yes	
Vital	ician: Th certificate rector, paç	Be	25. Was case referred to medical examiner?						26. Place	of Deat	h (Check only o	one)		
>	d in	2	1 ☐ Yes Ø No	Hospital: 1 Inp		ER/Outpatie	the second second		4 🗆 INL	ursing Ho	me Resi	dence 6	Other (Spe	cify)
D C	ffer ne		27. Manner of Death Natural 5 Pending	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury		8c. Injury Work			28d. Describe	how injury	occurred	
sio	Attending r death.	cati	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2	No	005 1	· · · · · · · · · · · · · · · · · · ·	44	and On the Market
Division of	tal or Attendir rs after death. al Diractor: A ed in by the fu	Certification:	4 Homicide determined	286. Place 0	f Injury - At h j, etc. <i>(Specii</i>	ome, farm, st	reet, factory	, office			City or To			ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fo	edicai	29a. Certifier (Check only one) Certifying Ph		is of examina							date and	place, and due	to the cause(s)
	To t To t	2	29b. Signature and title of certifier	1					number	_		,	e signed (Mont	th, Day, Year)
	102		But Pe					D36	57	0		1/3	3/05	
	600		30. Name and address of person who contact to P - T	ENO ITS	= MD	56	OR		25 (t	Æ	DR 3	SMLI	SBURY	and 51801
	St Regist	ate	31. Date filed (Month, Day, Year)	7005 32. R	istrar's Signa	ature .	bout	9						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 42743 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 12:30 PM December 30, 2004 Ralph Hill /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Salisbury
If Under 1 Year | If Under 24 Hrs. |
Months Days | Hours | Min. | Wicomico Anchorage Nursing Home 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Months 1**∏** M 2□ F Director 220-32-1947 Usuel Residence of Decedent September 14,1935 Maryland 69 the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County ral, or itema 23a or 28e-f ehow Examiner must be notified at Salisbury 10f. Zip Code 1 X Yes 2 □ No Directo Maryland Wicomico 10g. Citizen of What Country? filed within 72 hours after death with the Hygiene. USA 21801 105 Times Square Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Mamed 2 ☐ Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Oates: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed the Mudical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien. Important: If Item 27 is marked other than any injury or other traumatic event, ILE, 2008. Agricultural Farmer 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ethel Figgs Hill Lula Hyland Washington P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 527 Alabama Avenue Apt. 20, Salisbury, Maryland21801 Mary Virginia Cox (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Bunal 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Melson's UMC Cemetery January 3, 2005 Delmar, Delaware 21. Signature of Funeral Service Licenses Holloway Funeral Home Professional Association Kert verses 501 Snow Hill Road, Salisbury, Maryland 23a. Pert1. Enter the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** A(CV) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown δ been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ should be 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 113/05 Natur 147094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SACISBURY MD 21804 NATESAN STREET 5. DI VISI AN 1415 31. Date liled (Month, PAYN ear) 3 2005 32. Resistrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

			For State Registrar	State of Marylan		rtment of H			Dieme 0 0 4	42744
Dhw	ala ia		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day Ye	3. Time of Death
Phys /Me	sicia edica	al .	CATHERINE	E .		HERL		Decem	62226,20	c4 2331 M
Exa	mine	r	4a. Facility Name (If not institution, give stre	eet and number)	.41	4b. City, Town, or	r Location of Death		4c. County of E	eath Marco
			FLN/NSULA REGIONAL 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Upder 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign
Fune Direct				2 X F 78	* 1	Months Days	Hours Min.	(Month, Day APR. 16	r, Year)	Country) NNSYLVANIA
			Usual Residence of Decedent						, -,	
larylan show		_	10a. State 10b. County		y, Town or Lo	cation				10d. Inside City Limits 1 X Yes 2 □ No
vith the Ma or 28a-f		Director	MARYLAND WORCESTER	R 00	CEAN C	TY 10f. Zip Code			10 011 (1111	
with t			10e. Street and Number	IINTER OH					10g. Citizen of What	Country?
be filed within 72 hours after death with the Maryland hall Hygiene. The colors than "neture!", or items 23a or 28a-1 show went. It have noted that the colors than a show went.		Funeral	7604 COASTAL HWY	Was Decedent Ever in U.	S. 13. V	21842 Vas Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	pacify Yas or No-	USA 14. Race - A	merican Indian,
after o		ᆵ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No				Rican, etc.)		/hite, etc.
ours a		à	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		☐ Yes 2X No	Specify:		Specify:	WHITE
72 h		Completed	15. Decedent's Educat (Specify only highest grade of	ion ompleted)	(Give		during most of work	king	16b. Kind of Busine	ss/Industry
within ne.		du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired ACCOUNTA	*		САТНОТ ТС	CONFERENCE
filled v Hygie ther t			17. Father's Name (First, Middle, Last)		l	ACCOUNTA		ne (First, Middle,	Maiden Sumame)	CONTERENCE
d be ental ked o		To Be		IcGUIRE				ERINE	DONA	मााम
is 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. Health and Mental Hygiene. The action of 1 is marked other than "neturel", or Items 23a or 28a-1 show other theumetic event.		-	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street			r, City or Town, Stat	
and 2 ealth a n 27 is			EDWARD W. HERL/SON		51 SN	OWBIRD T	RAIL, FAI	RFIELD,	PA. 1732	0
as 1 and 2 of Health item 27			20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Ren		lace of Disposemetery, cren	sition (Name of natory or other place	:e)	Date	20c. Location - City	or Town, State
Pages nent of I			1 ☐ Burial 2 ☑ Cremation 3 ☐ Hen 1 ☐ Donation 5 ☐ Other (Specify)	noval from State	-		ARVA 12/2	8/04	DELMAR, 1	DELAWARE
permit. Pages 1 and 1 Department of Health Important: If item 27 any injury or other if	once.		21. Signature of Funeral Service Licensee	1 1		. Name and Addre		_		
1 85E	ä		Tobert WA	aris of.					BYVILLE,	DE. 19975
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that calused the death cause on each line.	n. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
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/Medic Examin			resulting at death)	Due to (or as a consec	uence of):					
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uted 1		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the deryling Cause (Disease or injury that initiated events	D- 1 - 1	la sa :					
exection and the article of the arti		Exa	resulting in death) Last	D to (or as consequent	uence of):					
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and components within in by the funeral director, page 2 should be detached for use as the burial-transit		dical	d.							
rtifica ng ph		Φ .	IF FEMALE:							
ath ce ttendi		Physician/M	23b. Was decedent pregnant in the past 12 months?	. If yes, outcome of pregna 1□Live birth 2□Feta	death 3	Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
ie dez		/sici	1 Yes 2 No	4☐Pregnant all time of de 9☐Unknown	eath 5	Other (specify)			(VICITE)	Day Tour
hat the sed by			Part II. Other significant conditions contri	buting to death but not res	ulting in the ur	iderlying cause niv	en in Part I	23e. Did to	bacco use contribut	e to the cause of death?
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ne lav		ш						autop:	sy prior	autopsy findings available to completion of cause of 1?
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vicial s cert		o O	examiner?	pital: 1⊿Inpatient 2□	ER/Outpatien	3 DOA Oth	er: 4 Nursing H		ence 6 Other (5	inecify)
a Physer this		-	27. Manner of Death	28a. ate of Injury (Month, Day Year)	28b. Time of	28c. Injur	y at		ow injury occurred	респу
ath.		atlo	1 Natural 5 Pending 2 Accident investigation	(MONIN, Day 16ar)	Injury		Yes 2 □ No			
recto		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specifi	ome, farm, stre	eet, factory, office		28f. Location (S City or Tow		Rural Route Number,
rel Di										
To the Hospitel or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending promotes within in by the funeral director, and 2 should be detached for use as		Medical	(Check only 2 Medical Examine)	ian: To the best of my kno r: On the basis of examina	wledge, death tion and/or inv	occurred at the tire estigation, in my o	ne, date and place, pinion, death occur	and due to the or red at the time, o	ause(s) and manne late and place, and	as stated. due to the cause(s)
thin 2 the		Med	29b. Signature applifile of certifier	and manner stated.		29c. Licens	e number		29d. Date signed (M	onth. Day. Year)
Z Z Z Z	3			general control						
10 M			50. Name and address of person who com	pleted cause of death (fter	23a) /Type	Print)	20-76 19	/	426/6	oy.
///			101 M. 12-1	Street	5/	4 6 -	054879	7	1801 Fre	g Treuth, M.D.
50	Stai	e	31. Date filed (Morth De Yard 200	32. Registrar's Signa	ture 4	loal	1		- 1	,
Reg	jistra	ır	2 J 200	1	/~	popula	2			

	_		1 - State Registrar	State of Marylar	-		t of He e of D			Reg. No	2 n n l.	42745
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last) REESE W. 4a. Facility Name (If not institution, give st]	HAMMO		ocation of D		ER 2	Year 7, 2004 County of Deat	3. Time of Death 4:40 A M
	Funeral Director		216-18-2901	AD 7. Age (In yrs. 81	last birthday) Yrs.	SAL If Under Months		If Under 24 I	Hrs. 8. Date of Bir (Month, Date 01-15-	th sy, Year)	Co) hplace (State or Foreign untry) ISBURY, MD.
	e Maryland Ba-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD WICOMIC		ty, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2X No
	be filed within 72 hours after death with the Maryland tal Hygiene. Id Hygiene. Id other than "natural", or terma 23a or 28a-f show event, I're Madical Examinat must be notified at	Funerai Dire	10e. Street and Number 32158 MT. HERMON RO 11. Marital Status 1 Never Married 2 Married	Was Decedent Ever in U Armed Forces?	1		2 dent of Hisp cify Cuban,	1804 Danic Origin? Mexican, Po	(Specify Yes or No		USA 14. Race - Ame Black, White	ncan Indian,
215-0036	nin 72 hours al in "natural", or Madical Exem	Completed by I	3 Widowed 4 Divorced 15. Decedent's Educ. (Specify only highest grade Elementary/Secondary (0-12)		16a. Dece	1 ☐ Yes : dent's Usua kind of word DO NOT us	al Occupati	Specify: on ring most of	working	16b. Ki	Specify: WI	HITE
N	be filed ntal Hygi of other event, I	Be	11 17. Father's Name (First, Middle, Last) ARLEY W. HAMMOND	College (1-401 5+)		SUPER'			Name (First, Middle	, Maiden	JLTRY IN Sumame)	NDUSTRY
Ž	ges 1 and 2 should be t of Health and Menta If item 27 Is marked or other traumatic ev	-	19a. Informant's Name/Relationship (Typ) GALEN R. HAMMOND — 20a. Method of Disposition	SON	-1	HAMM	(Street and	d Number or	Rural Route Numb	er, City o		LAND 21804
Baltimore,	permit. Pages Department of I Important: If it any injury or o once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeyal Service Licensee	emoval from State HAI	MMOND (natory or o CEMET I . Name an	ther place) ERY d Address	of Facility E	29-2004 OUNDS FUN	SALI NERAL	SBURY,	MARYLAND INC.
	Physician		23a. Pary . Enter the disease, or compressions, or heart failure. List only one Immediate Cause (Final disease or condition	Sations that caused the deal e cause on each line.	70	05 EAS	ST MA	IN STR	EET, SALI	SBUR	RY, MARY	T.AND 21804 Approximate Interval Between Onset and Death
	The law requires that the death certificate be executed by the law requires that the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consecutive to (or a))).	uence of):							
O. Box 6	at the death certific by the attending p tached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ac. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous 1 ☐ Dright Continuous 1 ☐ Dright Continuous 1 ☐ Dright Continuous 1 ☐ Dright Continuous 1 ☐ Dright Continuous 1 ☐ Dright Cont	Ideath 3□	Ectopic pro Other (sp				2	23d. Date of deli Month	very Day Year
ecords, P.	e law requires that has been signed b je 2 should be deta	Completed by Ph	Part II. Other significant conditions conti			nderlying ca	ause given	in Part I.		Yes 2[No 3 ☐ Pro	the cause of death? bably 4 Athliknown topsy findings available
		To Be Com	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Ho	ospital: 1 □ Inpatient 2 □	EP/Outpation	t 3□ DO			performance of the performance o	rmed? 2⊠ No one	death? 1 ☐ Yes	ompletion of cause of 2 ☐ No
Division of	ng Ph fter th ineral	Certification; T	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 2	8c. Injury a Work? 1 Ye	t s 2 \(\text{No}	28d. Describe I	how injury	y occurred	
NO.	To the Hospital or Attandi within 24 hours after death. To the Funaral Director: A completely filled in by the fu		4 Homicide determined 29a. Certifier 1 Certifying Physi (Check only 2 Medical Examine	28e. Place of Injury - At h building, etc. (Special cian: To the best of my known; On the basis of examina	y)	occurred a	at the time.	date and pla	City or Tox	vn, State)	and manner as	stated.
)	To the P within 24 To the C complete	Medical	29b. Signature and title of certifier	and manner stated.		29c	. License n Daを好答し	umber		29d. Date	e signed (Month	
	7 / Sta Registr		30. Name and address of person who com TANK A. (A. () 31. Date filed (Month, Cay Year) DEC 28 201	Mr 560 Runged	i Dr. 5.	Print)	Ms 2	-lgo;			*	

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	partment of Fertificate of	lealth and Me Death		en@ () ([42746
			1. Decedent's Name (First, Middle, L	.ast)			2.	Date of Death		3. Time of Death
	Physici /Medic	al	VINCENT 4a. Facility Name (If not institution, g	PAUL		ORGAN	Der Location of Death	Month ecember	22, 2004 4c. County of Deat	9:33 A ^M
	Examin	ęr	, ,	· · · · · · · · · · · · · · · · · · ·		Olney	Location of Death		Montgomer	
	Funeral		Montgomery Gener 5. Social Security Number 6.		<u>т</u> je (In yrs. last birthda) If Under 1 Year	If Under 24 Hrs. 8.	Date of Birth	9 Birt	hplace (State or Foreign
В	Director		087.14.6970	1 ☑ M 2□F	81 Yrs.	Months Days	Hours Min.	(Month, Day,) ar. 28,	Year) Co	untry) York
	P.		Usual Residence of Decedent				110	209	1,723 140 W	TOLK
	ırylar show	_	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Ba-f e	cto	Maryland Montgo	mery	01ney					1 ☐ Yes 2 🙀 No
	ih th	Dire	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	untry?
	ath w	ral	18905 Olney Mill				0832		U.S.A.	
	filed within 72 hours after death with the Maryland Hygiene. kther then "naturel", or Items 23e or 28e-f ehow ent, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	•	 Was Decedent of H If Yes, specify Cubi 	lispanic Origin? (Specif an, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, White	
36	, or l	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Types 2 1 If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 No	Specify:		Specify:	
8	hour ture	edt	15. Decedent's			edent's Usual Occup	ation	16	6b. Kind of Business/l	ite
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or Items 23e or 28e-f ehow enty injury or other traumatic event, the Medical Examiner must be notified at once.	o B	Daniel F	7.	Horgan		Elizabeth		Sulliva	ın
ary	short and A s ma	-	19a. Informant's Name/Relationship				and Number or Rural R	Route Number, (City or Town, State, Z	ip Code)
Σ	and 2 alth alth 27 is 27 is 8r tra		Eileen N. Horgan	ı / Wife	18905	01ney Mi	.11 Road, 0	lney, M	aryland 20	832
J'e	T S S S S		20a. Method of Disposition		20b. Place of Disp cemetery, cr	osition (Name of ematory or other place	Date	20	Oc. Location - City or	Town, State
altimore,	Page nent ont: II		1 ☐ Burial 2 【ACremation 3 `4 ☐ Donation 5 ☐ Other (Spec				ory 12/31/	2004 B	rentwood	Marul and
a	rmit. partn porte y inju		21. Signature of Funeral Service Lice	ensee		22. Name and Addre	ss of Facility HINE	S-RINAL	DI FUNERAL	HOME, INC.
m	8 5 5 8		Nanay A.	Lecent						ng, MD 20904
r	ju j		23a. Part1. Enter the disease, or co shock, or hear failure. List on	mplications that caused	d the death. Do not e					Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	, RENAL F						Onset and Death 4 Days
•	/Medical		resulting in death)	ш.	a consequence of):					4 Days
	Examiner		Constant list and dates	CIRRHOS	IS of the	LIVER				2 Years
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	cuter	Examiner	Cause (Disease or injury that initiated events	с						
O,	be executed sician and burial-transit		resulting in death) Last	Due to (or as	a consequence of):					
8760,	icate be executed physician and s the burial-transit	dlcal		d						
9		Med	IF FEMALE:							
Вох	death certifi e attending I id for use as	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy			23d. Date of delin	very Day Year
o.	0 0 0	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant at 9∏Unknown	t time of death 5	Other (specify)			Wichter	Day real
<u>.</u>	that the	Physiclan/Me	Part II. Other significant conditions	contributing to death h	ust not requising in the		and Book	OOn Did tob.		M
ŝ	law requires that the as been signed by th 2 should be detache	þ	Diabetes	contributing to death b		Artery Di			cco use contribute to	bably 4 Unknown
Records,	w requ	Completed						1 1 192	2140 3[] FIG	JOANN 4 DORKHOWN
ec	e 2 s	nple	Thrombocytopenia	<u> </u>	Hypertens	sion		24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
<u></u>	en: The lav	S	Normal pressure	Hydrocepha	lus			performe	id? death? I∏Yes 1☐Yes	2 🗆 No
	icien: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death (C	heck only one)		
0	Phys this al dir	J.	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 X Inpatie			4 Nursing Rome		ce 6 ☐Other (Spec	ify)
<u></u>	ding I After funer	o	1 ⊠Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injury	Wor	k?	. Describe now	injury occurred	
<u>S</u>	ttenc death stor: the	icat	2 Accident investigate 3 Suicide 6 Could not	he	un. Athene form		Yes 2 □No	Landing (Can	-1	-10
Division of Vital	or A after Dirac in by	Certification:	4 Homicide determine	building, et	ury - At home, farm, s c. (Specify)	treet, ractory, office	281.	City or Town,	et and Number or Rui State)	al Houte Number,
	spitel ours a nerel filled		29a. Certifier 1 X Certifying F	hysician: To the bost	of my knowledge, dea	th occurred at the ti-	ne, date and place, and	due to the en	20/2) and ======	stated
	24 hos 24 hos 5 Fun etely	edical	(Check only 2 Medicel Exe	eminer: On the basis of and manner sta	f examination and/or i	nvestigation, in my o	ne, date and place, and pinion, death occurred a	at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Diractor: A completely filled in by the fu	Me	29b. Signature and title of certifier			29c. Licens	e number	29d	I. Date signed (Month)	. Day, Year)
	,- ,- 0		I Cuch Art	-00		D1872	26	De	cember 22,	2004
	20		30. Name and address of person who	completed cause of d	leath (Item 23a) (Type			Бе		
_	Leafter 1		Arthur Schoengold				rive; Olne	y, Mary	land 20832	2
2	Sta		31. Date filed (Month, Day, Year)		ar's Signature	1 .				
I Se	Registr	air	DEC 2 9 2	004 Dens	Name D	Sparke	/			

State of Maryland / Department of Health and Mental Hygiene 42747 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Stanley Irvin Henry December 25, 2004 12:30 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2 Hahn Circle Walkersville Frederick 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Birthplace (State or Foreign Country) **Funeral** Months 1 ★M 2 ☐ F 67 Director 1937 Pennsyl<u>vania</u> 138-28-1323 1, Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28e-f shov 1 X Yes 2 No Directo Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Hahn Circle 21793 United States 14. Race - American Indian, Black, White, etc. ir than "natural", or items the Medical Examiner on 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1⊠Yes 2□No If Yes, Give 1955— Year or Dates: 107 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 1974 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygier Importent: If item 27 is marked other th, any injury or other treumetic event, the once. Chief Petty Officer United States Navv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Neal Henry Helen Lamb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorna J. Henry / Wife Hahn Circle Walkersville, MD 21793 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 28 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Resthaven Crematory 2004 Frederick, MD 21. Signature of Funeral Service Licentee 22. Name and Address of Facility kesthaven Funeral Services, Skkot Cody P.A 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease shock, or heart failure. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HODGANI /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner equires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Гoг in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 I Inknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed 1 ☐ Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: P Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this. 28a. Date of Injury (Month, Day Year) filled in by the funeral 27 Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a To the Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tit 29c. License number e of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Frederick, MD 2170 MD 501 Elhamy Eskander, 31. Date filed (Month) pa 32. Proistrar's Signature 2004 State 0 Registrar

Amended Item 5 per F.D. 01/05/2005 Carroll County, am Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 24 **Physician** December 10:15P [™] 2004 Starr Hartzler /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Ctr. Examiner Carroll Lutheran Village Health Care Carroll Westminster If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Dec. 15, 1914 9. Birthplece (State or Foreign 6. Sex 5. 2018 Septity (by7) 997 **Funeral** Days 1 □ M 2 🕇 F Mary land 90 217-01-0777 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be lifed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show eny injury or other traumatic event, the Mudical Examinar must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Director Maryland Carroll New Windsor 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 310 Church St. 21776 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritat Status Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: 3 ₺ Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cottege (1-4or 5+) funeral director funeral 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rockward Nusbaum Pearl Starr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel D. Hartzler/ son New Windsor, MD 21776 P.O. Box 249 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pipe Creek Cemetery 12/28/2004 nr. Linwood, MD 21. Signature of Fyheral Service Lice 22. Name and Address of Facility Hartzler Funeral Home Jan New Windsor, MD 21776 310 Church St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) veek Physician /Medical Due to (or as a consequence of): **Examiner** VRYR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, s been signe should be c Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 1 Yes 2 No Hospital or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 3 DOA 2 TER/Outpatient funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the form 2 T Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 27,2004 redungser WSZ PPPE COO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 S. H 307 Strer AR westminster. 295

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

3 0 2004

32. Registrar's Signature

Amended Items 10e & 19b per F.D. 12/30/2004 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Francesca Johnson 04-8349 State of Maryland / Department of Health and Mental Hygiene Reg. No. 0 0 4 AKG Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** FRANCESCA MARIE JOHNSON December 26, 2004 4:08 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Hospital Baltimore City If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 8 / 8 / 1 9 6 9 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 21X F Months 35 220-74-1019 Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ?7 ie marked other then "natural", or items 23a or 28a-f shov treumetic event, tre Madical Exeminer must be notified al BALTIMORE Director 1 ☐ Yes 2√ No MD. COCKEYSVILLE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 PINE BARK CT. 102 PINE PARK RD. 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XNo Specify: Specify: WHITE ۵ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 Ie marked other the eny injury or other treumetic event, Italy ODGE. ENVIRONMENTAL SCIENTIST 12 CONSULTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dr. Niel J. BORRELLI JOANNE KISSINGER 19a. Informant's Name/Relationship (Type, Print) PO 2 dail PANE es BARK and Tumber COCKEY SWITTEL Ety on My n, 2 TEO 30 Code) ROBERT JOHNSON PINE PARK RD., COCKEYSVÍLLE, MD. -HUSBAND 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MEADOW BRANCH CEM. 12/30/04 WESTMINSTER, MD. '4 □ Donation 5 □ Other (Specify)

21. Scinature of June 1 Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final imjuries Physician Multiple disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit be executed Due to (or as a consequence of): Box 68760 Physician/Medlcai use as t IF FEMALE 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death P.O. 1 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No autopsy performed? certificate Division of Vital 2 No the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 x Yes 2 □ No 1 Inpatient 2/ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 4 Passencer is rolved in motor 1 Natural 5 Pending 1 ☐ Yes 2 🗷 No 12/26/04 М death. investigation 1:06 2X Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined street Dullancy Valley at Pot spring Rd

124 hours a the within To the

WIL

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Commillal

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year)

O.C.M.E.

29c. License number

December 27, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Z + BI LILL + H L

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland

State Registrar

29a. Certifier (Check only one)

ORIGINAL

			For State Registrar	State of	Maryland .		artment of H			, ,	ene	n L	1,2750	
		2	Decedent's Name (First, Middle, Last)						2. Date of Death 3. Time of Dea				3. Time of Death	
ı	Physici /Medic		Anna K	Month Decemb				Day 18.	2004	10:20 P ^M				
	Examir Funeral Director		4a. Fecility Name (If not institution,	4b. City, Town, or Location of Death				4c. County of Death						
1		2	Casey House				Rockville				Montgomery			
r			5. Social Security Number 6. Sex 7. Age (In yrs. last				rthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			8. Date of Birth (Month, Day,				
	_		101-22-2473 Usual Residence of Decedent		76					June 4,	1928	New_	York, NY	
	within 72 hours after death with the Maryland ene. than "natural", or itams 23c or 28a-f show to Madical Exemirer mast be notified at		10a. State 10b. County		10c. City, T	own or Lo	cation					1	Od. Inside City Limits	
		ctor	Maryland Montgo	merv	Poto	mac							1 ☐ Yes 2X No	
		Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?									ntry?		
L		ra	10409 Gainesbor				20854				U.S.			
	tams trams	Funeral	11. Marital Status	12. Was Deced	es?	13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig ın, Mexican	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)	14. Ra	ace - Americ ack, White,	ean Indian, etc.	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat	X_INO es:		1□Yes 2□XNo	Specify:			Spec	ர்⁄ு Whit	te	
ŏ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or items 23c or 28a-f show any injury or other traumatic evant, Ira Madical Exemiter mant be notified at once.		15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry							dustry				
215		ple	(Specify only highest Elementary/Secondary (0-12)	kind of work done during most of working DO NOT use retired)										
Maryland 21215-0036		Completed	, , , , , , , , , , , , , , , , , , , ,	College (1-4 5+	.,	Tea	cher/Home	maker			Educ	ation	/Domestic	
		Be	17. Father's Name (First, Middle, La	st)				18. Mothe	r's Name	(First, Middle, M.	aiden Suma	ıme)		
<u> </u>		To	Harry Slonimsky							Bernetsk	-		-	
Mar			19a. Informant's Name/Relationship	(Type, Print)			ng Address (Street a							
			Louis Kalikow 20a. Mathod of Disposition	son			Howland A sition (Name of	ve. I				M5R3		
altimore,			1 Burial 2 □ Cremation 3		ate ceme	etery, crer	natory or other place	1					wn, State	
			 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Liquid 		Jude		em. Garde . Name and Addres			/2004 0				
8	Dep Imp		100 P 31	Do			1800 New						m MD	
r	death certificate be executed Wedical e attending physician and infor use as the buriat-transit		23a, Par 1. Enter the disease, o co	emplications that cau	ised the death. D							OPLINE	Approximate	
Ø			Shock, or heart failure. List or Immediate Cause (Final			iaht	Hamichha	ra CV	٨				Interval Between Onset and Death	
			Infinediate Cause (Final disease or condition resulting in death) Hemorrhagic Right Hemisphere CVA Due to (or as a consequence of):											
			Conventially list conditions	h										
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b										
		Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.										
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	physicate sthe	dical		d				_						
9 xo	certifi iding se as	/Me	IF FEMALE:	23c. If ves. outco	me of pregnancy									
Bo	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							3d. Date of delivery Month Day Year		
o		hys	1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	9□ Unknow		Jan Striet (specify)								
S,	res that the de signed by the a be detached f	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause given in Part I.									e cause of death?		
rds	Attanding Physician: The law require freath. re floath. rector: After this centificate has been s by the funeral director, page 2 should						1 🗆 Yes	1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown						
Hecord		plet					24a. Was an			osy findings available				
		Completed			1.0			autopsy prior to completion of cause performed?						
		Be C	25. Was case referred to medical examiner?					26. Place	of Death	1 Yes 2. (Check only one)	2140	1 103	20 140	
0		To	1 ☐ Yes 2 XNo	Hospital: 1 _ Inp	atient 2 ER/	Outpatien	t 3□ DOA Othe	or: 4 □ Nur	sing Hom	e 5 Residen	e 6 K iOti	her (Specify	Hospice	
<u></u>		ou:	1 Yes 2 No											
<u>s</u>		catl	2 Accident investigation 3 Suicide 6 Could not be 200 Bloom (Investigation Market State St											
DIVISION		Certification:	determined determined determined determined determined building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route No. City or Town, State)								Route Number,			
_	To the Hospital or within 24 hours after the Funaral Discompletely filled in		29a, Certifier 1 Certifying	Physician: To the be	act of my knowled	Ine don't	accurred at the t	o dota as d	I place a	ad due to the -	na/n) c = 1			
	24 h 24 h 5 Fun etely	edical	(Check only 2 Medical Ex	eminer: On the basi and manner	s of examination	and/or inv	estigation, in my op	e, date and inion, death	h occurred	d at the time, date	se(s) and m and place,	anner as sta and due to	the cause(s)	
	To th within Fo th	Me	29b. Signature and title of certifier	29c. License number 29d.				I. Date signed (Month, Day, Year)						
)			della	1/1		_	NU	121	12		10%	101/1	72/	
	13		30. Name and address of person wh	o completed cause	of death (Item 23a	a) (Type, I	Print)		0		-2/3	110	7	
			Charles M. Harris	son, M.D.	1355 Pic	ccard	d Drive; l	Rockv:	ille,	MD 208	350			
	Sta	te	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signature		Sporks							
	Registr	ar	DEC 2 9	2004		10	Laborator .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 0021 December 27,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL CONTER HICOMICO PENINSULA REGIONAL 50/156419 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours **X**□M 2□F Days Yrs. Director 213-14-1664 6-29-1923 Md. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 28a-f shov 10d. Inside City Limits other traumatic evant, the Medical Examiner - ust be nutified at Director 1 ☐ Yes 2 X No Wicomico Md. Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ , or Itama 23a Funeral 1937 Pine Way 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 PYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 N Married 1 ☐ Yes 2 🛣 No þ 3 Widowed 4 Divorced Specify: Hygiene. other than "naturel", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Toe Cut Operator DuPont Nylon Co. marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ith and Mental H Be William A. Layton Pearl Mumford Layton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if itam 27 Elma L. Layton, Wife 1937 Pine Way, Salisbury, Md. 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of ^¹ 4 □ Donation 5 □ Other (Specify) Wicomico Memorial Pk. 12-30-04 Salisbury, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed HAD of Vital 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation Injury 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled 24 hours a 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the H within 24 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Jeffrey

213-14

6.

Shole

400

32. Registrar's Signature

2004

DHMH 17 Rev 1/2001

ype or Print in Black Indelible Ink. Assure An Cop. State of Maryland / Department of Health and Mental Hygiene 2004 42753

Certificate of Death Reg. No. 3. Tima of Death

	- DI . °		Decedent's Nama (First, Middla, Last)						2.	Date of Death Month	Day	Yaar 3.	Tima of Death
	Physici /Medio		MELVIN W. LUKAT						D	ECEMBER	0 -		10:40AM
	Examir		4a Facility Nama (If not institution, giva street and number	er)			4	4b. City, Tov	wn, or Locat	tion of Death	4c. County	of Death	
		ş7.	BRADFORD OAKS NURSING &	REHAE	CEN	ITER		CL	INTON		PRI	NCE GE	ORGES
	Funeral		5. Social Sacurity Number 6. Sex 7.	Aga (In yrs. la	ast birthd	(ay) If Undar Months	1 Yaar Days	If Undar 2 Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day,	raar)	9. Birthplece	(Stata or Foreign
	Director		579 22 8149 Ж Хм 2□ F	86	Yrs	5.			JA	AN. 23,	1918	WASHI	NGTON, DC
Т	p .		Usual Rasidance of Decedant 10a. Stata 10b. County	10a City	Tourne	r Location						104 8	Insida City Limits
	ehov	-	Toa. Stata Too. County	Too. City	, TOWITO	Location							YYes 2 No
	N Pe M	Directo	MARYLAND PRINCE GEORGES	CLI	NTON		0.1			10	. 022		
	with the Maryland a or 28a-f show be notified at	ä	10e. Street and Number			10f. Zip						What Country?	
	£ 2	Funeral	7520 SURRATTS ROAD	at Francis III 6		D Was David		0735		1 -		STATES e - Amarican Ir	ndian
	or items	nu	11. Marital Status 1 Never Married 12. Was Dacada Armed Forca 1 Yes 2	is?	5. I	 Was Daced If Yas, spec 	ify Cuba	an, Maxicen	gin? (Specin , Puarto Ric	an, atc.)		ck, White, atc.	idian,
Z	rs of	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2X If Yes, Giva \$_X\vert Midowed 4 ☐ Divorced Yaar or Data			1□ Yas 🤅	XNo	Specify:			Specify	WHITE	
ξ	72 hours efter "naturel", or ite		15. Decedent's Education		16a. De	cedent's Usua	Occup	etion	7.	10	6b. Kind of B	usiness/Industr	у
2	in 72	Completed	(Spacify only highest grada completed)	- 5.)	(G	iva kind of wor e. DO NOT us	k dona e retired	during most d)	of working	:			•
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ġ	e filed Il Hygi other	Bec	17. Fathar's Name (First, Middla, Last)							irst, Middla, M	aiden Surnan	na)	
0	d 2 should be filed th end Mental Hyg 7 is marked othe traumatic event,	To B	FREDERICK LUKAT					LUCY	CHAN	ΕY			
ary	shound M		19a. Informant's Name/Ralationship (Type, Print)	,	19b. M	ailing Addrass	(Straat	and Numbe	or or Rural R	louta Number,	City or Town,	State, Zip Coo	fe)
Ĕ			SUZAN FOX / NEICE		1377	70 BALL	ANTI	RAE LA	ANE	WALDO	RF, MD	20601	
ย์	s 1 en f Heal frem 2 other		20a. Mathod of Disposition	CO	ace of Di	sposition (Nam	na of	re)	1	Date 20	Oc. Location -	City or Town,	State
aitimo	8 = 5		XXBurial 2 ☐ Cramation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	ta		ILL CEN			112	/30/04	CIITT	LAND, N	AT)
	nit. Perartmen ortant: Injury 8.		21. Sign Jura of Funaral Sarvice Licensaa	CED	AK II	22. Name and	d Addre	ss of Facility	v				
Ď	permit. Departr Imports any Inj		11. P m 101							OME OF			•
	-		23a Part 1 From the disease or complications that cau	sed the death	Do not	4308 S						20746	proximate
i.			23a. Part1. In ar tha disaasa, or complications that caus shock, or heart failura. List only one cause on each	lina.	. Do not	Ontor the mode	2 0. Oyli	ig, caoir ao	04.0120 01.10	aopiratory alloc		Inte	erval Batween set and Death
	Physician /Medical		Immediata Ceuse (Final									-	MEADC
	Examiner		disaasa or condition resulting in death) a. PROS'.	TATE CA								3	YEARS
Ш		ē				saquance of):	- 4-	D-05				1	MEADO
	uted ansit	Examiner	0.			C VASCU	LAR	DISEA	ASE			5	YEARS
•	n and iel-tre	Exa	Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarlying	Due 10 (01	as a con	isaquarice oij.							
00/00	e be rsicia e bur	edicai	that initiated avants	Dua to (or	as a con	saquanca of):							
8	The law requires that the death certificate be executed ate hes been signed by the attending physician and page 2 should be deteched for use as the buriel-trensit	8	rasulting in death) Last	2 44 (5.									
5	andin use	cian/Me	d										
0	deatl		Part II. Other significant conditions contributing to death	n but not rasu	Iting in th	a underlying ca	ause giv	en in Part I.		23b. Did tob	acco usa co	ntribute to the	cause of death?
	t the	À								1 ☐ Yes	2 □ No	3 Probably	y XIX Unknown
'n	s tha	by F											
cords,	w requires that the di been signed by the should be deteched	Completed by Phys								24a. Was an	autopsy	availab	utopsy findings le prior to
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ב ב	The It	E								1☐Yes	XXXNo	1 □ Ye	s 2□No
9	an:] tifice tor, p	Bec	25. Was case referred to medical					26. Place	of Death (C	Check only one)		
5	s cer direc	To B	examiner? 1 Yes YZX No Hospital: 1 Inper	atient 2 🗆 E	ER/Outpa	itient 3 DO	A Oth			5 🗆 Rasidan		ar (Specify)	
5	Phy erthi		27. Manner of Death WYN Naturet 5 □ Pending (Month.)	njury	28b. Tim Inju	e of 2	8c. Injur Wor	y at		d. Dascribe hov			
5	ath. r: Aft	atio	XXNaturet 5 ☐ Pending (Month, I 2 ☐ Accidant invastigation	Day (bar)	inte	M		Yas 2 1	No				
	Atte	£	3 ☐ Suicida 6 ☐ Could not be determined 28a. Place of building.	Injury - At hor etc. (Specify,	me, farm,	, straat, factory	, office		28f.	Location (Stra		ar or Rural Ro	uta Numbar,
5	s effection of the part of the	Certification:	4 El Homoda building,	oto. (Opecny,	/					Only or round	0.2.0,		
	To the Hospital or Attending Physician: The law within 24 burus effer death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2		29a. Certifiar (Check only (Check only 2 Medical Examiner: On the basis										
	he H in 24 he Fi	edical	one) and mennar		011 6110/0								
	To To To To To To To To To To To To To T	Σ	29b. Signatura and titla of certifiar	7		29c	. Licans	a number		29	d. Data signa	d (Month, Day,	Year)
			1. W. 8.					D45365	5		DECEM	BER 29,	2004
	121		30. Name and address of person who complated causa of	of daath (Itam	23e) (Ty								
	7		MICHAEL SIDAROUS, MD			11701	LIV	INGST	ON RD.	#101	FT. W	ASHINGT	ON, MD
	Sta		31. Date filad (Month, Day, Year)	strar's Signat	ura								
	Registr	ar	DEC 3 0 2004 Service	مجار ب	150	are .							

DHMH 16 Rev 6/95

			For	State of Marylan				Mental Hygi	9	
			1 - State Registrar		-	rtificate of			g. 2004	42754
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Mildred Louise Lea						23, 2004	12:35 A ^M
	Examin	er	4a. Fecility Name (If not institution, give s Heritage Harbour l			Annapo	r Location of Death		4c. County of Death Anne Ar	undol
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		place (State or Foreign
	Director		579-42-4404	M 2 X F 71	Yrs.	Months Days	Hours Min.	July 1,	1933 Wash	ington, DC
	ryland how		10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
	8a-ts	cto	Maryland Anne A	rundel	Annap					1 ☐ Yes 2X No
	with ti	Dir	10e. Street and Number 996 Riversedge Cit	ralo		10f. Zip Code	1401	10	g. Citizen of What Cou USA	ntry?
	ms 23	erai		12. Was Decedent Ever in U.	.S. 13.		lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14. Race - Ameri	can Indian,
36	within 72 hours after death with the Maryland ene. than *natural', or Items 23e or 28e-f show the Mudical Examinatings for notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ∐Yes 2001 If Yes, Give		if Yes, specify Cuba 1 ☐ Yes 2 【XNo		Rican, etc.)	Black, White,	
000	tural'	ed b	3XXVidowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a. Dece	dent's Usual Occup	pation	1	6b. Kind of Business/In	ite
21215-0036	hin 72 an na Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life.	kind of work done DO NOT use retired	during most of world)	king	55. Time 5. 550m555	20007
2	ed with	Com	11th		Home	maker			Home	
and	be fill ad oth sven	Be	17. Father's Name (First, Middle, Last)	wood Slocombe			18. Mother's Nam	ne (First, Middle, M.		
Maryland	should be and Mental I smarked o	2	WIIIIalli Lelli 19a. Informant's Name/Relationship (Ty)		19h Mailir	no Address /Street	and Number or Ru	Mary Lou	City or Town, State, Zip	Code)
	and 2 saith an n 27 is		Kimberly A. Leaman	n/ Stepdaughte	er 2	504 Howar	rd Grove 1		dsonville,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic svent, the Mudical Examination in the notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 R	emoval muni State		sition (Name of matory or other place Crematory	I		Dc. Location - City or To	
Ħ	nit. Parame ortani injury		'4 ☐ Donation 5 ☐ Other (Specify) 21. Signate of Juneral Service Ligense			_	' '		Edgewater, alas Funer	
ä	Depar Impo		> what o'llar	er	2:	973 Solom	ons Isla	nd Rd. Ed	gewater, M	D 21037
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death ie cause on each line.	h. Do not ent		-			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ		Bre	ast C	Meta	stasis	
	Examiner				derice ory.					
	D #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):			-		
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	. Due to (or as a consequence	neace of):					
3760,	icate be executed physician and s the burial-transit	cai E		1	301100 01).					
3	ifficate g phy: as the									
Вох	leath certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal		Ectopic pregnancy	,		23d. Date of deliver	ery Day Year
P.O. E	The law requires that the death certifics are has been signed by the attending pt page 2 should be detached for use as t	Physician/Med	1 Yes 2 No 9 Unknown	4□Pregnant at time of de 9□Unknown	eath 5	Other (specify)			WOTH	Day 16a1
	res that igned b	by Pł	Part II. Other significant conditions con	tributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
ord	w require been sig should b	ted I	tache to	Thrine				1 Tes	2 □ No 3 □ Prot	bably 4 Unknown
Records,	elawr hasbe je 2 sh	Completed						24a. Was an autopsy	24b. Were auto prior to co	psy findings available mpletion of cause of
alF	Physician: The this certificate har director, page							perform 1 Yes 2		2□ No
Vital	sician s certifirecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 H	lospital: 1 Inpatient 2	ER/Outpatier	it 3□ DOA Oth		th (Check only one) ce 6 □Other (Specif	
J Of	Attending Physician: r death. ector: After this certification, the funeral director, by the funeral director.	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time or			28d. Describe how		y)
sior	ittending F death. stor: After i	atio	1 Natural 5 Pending 2 Accident investigation	(World, Day Year)	mary		Yes 2 □ No			
Division	l or Att after d Direct i in by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str y)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	d Route Number,
	To the Hospital or Attan within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	(Check only 2 Medical Examir	sician: To the best of my kno ner: On the basis of examina	wledge, deatl	n occurred at the tir	me, date and place, pinion, death occur	and due to the cau	ise(s) and manner as s e and place, and due to	tated. the cause(s)
	To ths within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	290	d. Date signed (Month,	Day, Year)
)			KADITYA	CHOPRA		DS	7028-	12	2-23-04	
			30. Name and address of person who co	mpleted cause of death (Item	/) '	Print)	710 0	1 22.	Auga 1.1	MD 21401
	Sta	te.	31. Date filed (Month, Day, Year)	32. Resistrar's Signa	Kid	gely 1	de Ju	Le 23/	mnapolis	M1/2/40)
	Registr		DEC 28	2004 Been	J.	book			1	

			1 - For State Registrar	State of Maryla		artment of H			giene Reg. No.2001	42755
	Physici /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Rita Alison Lyr					2. Date of Dea Month Decembe	er 26, 2004	3. Time of Death 4 11:45 P M
)	Examir	ner	4a. Facility Name (If not institution, give s 11 Brice Road			Anı	Location of Death		4c. County of Dea	rundel
	Funeral Director		5. Social Security Number 6. Sex 1 Security Number 1. Security Number	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day October		rthplace (State or Foreign ountry) Massachusetts
	with the Marylan a or 28e-f show Le notified at	Director	Maryland Anne Art		ity, Town or Lo	is 10f. Zip Code			10g. Citizen of What C	
9036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-f show the Medical E-aminer must be notified at	d by Funeral	11 Brice Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		21401 Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	spanic Origin? (Sp n, Mexican, Puerto Specify:		United Sta 14. Race - Am. Black, Whi Specify: Wh	erican Indian,
Maryland 21215-0036	ad within 72 h /giene. ar than "natu i, I'e Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired memaker	ation during most of work)	ing	16b. Kind of Business own hom	
aryland	should be file and Mental Hy s marked oth umetic evant	To Be	17. Father's Name (First, Middle, Last) William A. Burns 19a. Informant's Name/Relationship (Ty)	рө, Print)	19b. Mailir	ng Address (Street a		eth McGo		Zip Code)
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked othar than "natural", or Items 23a or 28e-1 show any injury or othar treumetic evant, It a Madical Examinat must be notified at once.		Marvin Lynch/ hus 20a. Method of Disposition 1	emoval from State	11 B Place of Dispo cemetery, crem altimor	rice Rd. sition (Name of natory or other place e Cremato . Name and Addres	Annapoli: ory Dec. s of Facility Join	s, MD 21 Date 28, 200 hn M. Ta	401 20c. Location - City or 4 Baltimor	Town, State re, MD ral Home, Inc
8760,	Cate be executed // Medical Examiner bhysician and sthe burial-transit	dical Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	ath. Do not entered to be shown a quence of):		g, such as cardiac	or respiratory arre	est,	Approximate Interval Batwaen Onset and Death
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
Records, P	w requires that been signed b should be dete	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	nderlying cause give	n in Part I.		pacco use contribute to	the cause of death?
Vital Reco		e Completed	25. Was case referred to medical					24a. Was ar autops perform 1 Yes 2	y prior to death? □ □ No 1 □ Yes	utopsy findings available completion of cause of
o	ing Phys After this uneral dir	To B	examiner?	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	26. Place of Death 4 \(\text{Nursing Ho} \) at ? es 2 \(\text{No} \)	me 5 🗗 Reside	a) ince 6 □Other (Spec w injury occurred	cify)
DIVISION	spitel or Attand ours after death naral Director: /	al Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Special cian: To the best of my kn	ify)			City or Town		
	To the Hospitel within 24 hours a To the Funaral I completely filled	Medical	(Check only 2 Medical Examin one) 29b. Signature and title of certifier	er: On the basis of examinand manner stated.	ation and/or inv	estigation, in my op	inion, death occurr	ed at the time, da	ite and place, and due	to the cause(s)
			30. Name and address of person who cor	npleted cause of death (Ite	m 23a) (Type, I	Print) Helico	CT S	-itc	2 / 28 / 28 / 28 / 28 / 28 / 28 / 28 /	agolis.
:0	Sta Registr	1	31. Date filed (Month, Day, Year) DEC 2 8 21	32. Registrar's Sign	ature /	book				

			1- For State of Maryland / Dep	eartment of Health and Mertificate of Death	lental Hygie	2004 42756
			Registrar 1. Decedent's Name (First, Middle, Last)	Timoale of Death	Reg 2. Date of Death	. No. 3. Time of Death
п	Physici				Month	Day Year
	/Medic Examir		Monica Rose Lockard 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Dec. 3	0, 2004 11:48 P M
Н	LAdillii	ic:	21368 South Essex Drive	Lexington Park		St. Mary's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Director		273-40-4742 1 M 2 F 59 Yrs.	Months Days Hours Min.	(Month, Day, You	1945 Ohio
	D >		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L			
	shor	7				10d. Inside City Limits 1 ☐ Yes XXNo
	the M	Director	Maryland St. Mary's Lexingto			
	with	급	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	10f. Zip Code		. Citizen of What Country?
	eath	era	21368 South Essex Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20653 Was Decedent of Hispanic Origin? (Spe		U.S.A. 14. Race - American Indian.
	fter d r Itan irer	Funeral	1 Never Married Armed Forces? 1 Never Married Types 2 No 1966—	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
93	within 72 hours after death with the Maryland one. then "naturel", or Items 23s or 28e-f show the Maciliad at he matter the Maciliad at	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1968	1 ☐ Yes 2 No Specify:		Specify: White
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7	filad w Hygien other th	Con	4 Nu	se		Health Care
m	be fill	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Mai	den Sumame)
Maryland 21215-0036	ges 1 and 2 should be filad within 72 hours after death with the Marylan tof Haalth and Mental Hygiene. If item 27 is marked other then "naturel", or Itams 23a or 28e-f show or other treumatic event, Ite Medical Examiner must be notified at	2	Vincent L. Beck	Rose Ann		
Ma	d 2 s th an th an treur			ing Address (Street and Number or Rura		
	parmit. Pages 1 and 2 Department of Haalth a Importent: If item 27 is any injury or other treu		20a. Method of Disposition 20b. Place of Disp	8 South Essex Dr.,		on Park MD 20653 Location - City or Town, State
altimore,	ages ant of it: If i		1 Burial 2 Cremation 3 Hemoval from State	matory or other place)		
Ħ	nit. F artme orten injur		Oak c	Frove $1-7-1$ 2. Name and Address of Facility Bri		Logan, Ohio
ä	parmi Depa Impo any ir		David A. Goff TOWN01095 2	2955 Hollywood Ros	instieta i	runeral Home, P.A. Itown, Maryland 20650
			23a. Part1. Enter the disease, or complications that caused he death. Do not en shock, or heart failure. List only one dayse on each line.	ter the mode of dying, such as cardiac of	r respiratory arrest,	Approximate
8	Physician		Immediate Cause (Final disease or condition			Interval Between Onset and Death
	/Medical		resulting in death) a. Due to (or as Vconsequence of):			
В	Examiner		Sequentially list conditions, b			
	p tig	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	and I-tran	Examiner	that initiated events resulting in death) Last C			
8760,	cate be axecuted physician and the buriat-transit		Due to (or as a consequence or).			
687	The law requires that the death certificate be axecuted attentions been signed by the attending physician and cage 2 should be detached for use as the buriat-transit	edical	d			
	leath certific attending p	Z/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
m	death e atte d for	Icla	in the past 12 months? 1 Yes 2 10 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other <i>(specify)</i>		Month Day Year
P.O. Box	that the de ted by the a detached	Physician/M	9 ☐ Unknown 9 ☐ Unknown			
	ignad be det	by P	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
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ecc	law r as be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
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	Physician: r this certific ral director.	ပ	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien			6 ☐Other (Specify)
Division of	Jing After fune	on	27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how in	njury occurred
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<u>></u>	after after Dire	Certification:	4 Homicide determined 200. Place of Injury - At home, farm, st building, etc. (Specify)	eet, ractory, office	City or Town, St	and Number or Rural Route Number, ate)
	spite		29a. Certifier 1X Cartifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place, a	and due to the cause	a(s) and manner as stated
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical	(Check only one) 2 Medicel Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	ed at the time, date	and place, and due to the cause(s)
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	ž	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	00		1 ymu	H00557	5/	1/3/05
7	81		30. Name and address of person who completed cause of death (Item 23a) (Type,			
			Jennifer Schmidt, M.D. 23415 Thr 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature	ee Notch Road Cali	fornia, M	Maryland 20619
	Sta Registra		31. Date filed (Month, Day, Year) JAN 0 4 2005 32. Poistrar's Signature	Garles		
			Market Son De Val			

68760. ۵.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛭 🕽 👢 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Catherine T. McCain 11:06 AM /Medical 2004 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONAL 5AL1364N KICOM 100 If Under 1 Year | If Under 24 Hrs Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 5/22/1931 Birthplace (State or Foreign Country) Days 1 ☐ M 2 X F Hours 73 Director 220-26-7720 Yrs Maryland Usual Residence of Decedent with the Maryland 10b. County Show 10c. City, Town or Location itam 27 le marked other than "natural", or items 23a or 28a-f shor other treumatic event, it a Martical Examinar must be notified at 10d. Inside City Limits Director Maryland Wicomico 1X Yes 2 □ No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 118 Hall Drive 21804 death v **USA** Funeral 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2X Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 le marked other than eny injury or other treumatic event. It a Market. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter L. Timmons Mary Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. McCain/husband 118 Hall Dr.,Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Wicomico Memorial 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☒ Other (Specify) Entombment 12/30/04 Salisbury, MD T F meral Service Licer 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 236. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC LUNG CANGER 6 MONTHS. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Insease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner law requires that the death certificate be executed resulting in death) Last physician a Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. the Ö 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 No Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physicien: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To Other: of 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Division 1 Natural 5 Pending after death. investigation 2 Accident 1 Yes 2 No 6 Could not be determined within 24 hours after de To the Funerel Directo completely filled in by th 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Now 2057359 2rle December 28/5 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 72 21504 S. DIVISION ST SAUSBURY DR. USHANATESAN 2º19 2004 32. Registrar's Signature State works Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Year Physician ESTHER TILGHMAN MURRA 2004 0600 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner W) Comico SALIS BURY MIFR HEAD HOSPITAL DEERS If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months 1□M 2XF Hours Director 214-10-9338 08-11-1912 Maryland permit. Pegas 1 and 2 should be filed within 72 hours after deeth with the Meryland Department of Heelth and Maniel Hyglens. Important: if them 27 is marked other than "naturel", or items 23a or 28a-f show eny injury or other treumstic event, the Medical Exemina. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1) Yes 2 □ No Director Salisbury 101. Zip Code Wicomico 10e. Street and Number 10g. Citizen of What Country? 1514 Pine Bluff Village 21801 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1□ Yes 20(No Specify: è 3K Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Saleswoman</u> Retail Business 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph William Rufus Tilghman Minnie E. Dryden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Roberts/Daughter 300 Roberts Lane, Stevensville, MD 21666 20a. Method of Disposition

12 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Asbury U.M. Cemetery 12/23/04 Mt. Vernon, Maryland 22. Name and Address of Fecility Hinman Funeral Home 21. Signature of Euneral Service Licensee Part1. Enter the dischse, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fails e. List only one cause on each line. 11673 Somerset Ave., Princess Anne, MD 21853 Physician PulmoNARY EDEMA

Due to (or as e consequence of):

CONGESTINE HEART FAILURE

Due to (or as e consequence of): /Medical Immediate Cause (Finat disease or condition resulting in death) Examiner Physician/Medical Examiner attending physician and for use as the buriel-transit or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last AHHEROSCLEROSIS CARDIAC DISEASE Division of Vitai Records, P.O. Box 68760. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknowh ģ After this certificate has been signed funarel director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an eutopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 Yes 2 No 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At completely filled in by the fu 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 11 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier D33905 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

DEC 2 8 2004

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32. Registrar's Signature

0 Boy 2018 SALISBURY Ad 2,802-2018

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** December 20, 2004 Elizabeth Mills 3P.M. /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cherry Lane Nursing Center Laurel Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Oay, Year) December 8,1914 Birthplace (State or Foreign
Country) **Funeral** 1 M 2 F 578-28-0891 90 Director Yrs. Washington, D.C. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or iteme 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Maryland Howard 1 XYes 2 No Directo Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 9563 Wandering Way 21045 U.S.A. Funerai Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "natural", or Iter 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No ģ Specify: Black 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Sth. grade College (1-4or 5+) Domestic Engineer Housekeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is ir any injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Numbe. Mr. Ramon Jarvis (Friend) 7227 Dockside Lane Columbia, Maryland 21045 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY, INC. December 23,2014 Reltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rollins Fuers Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 ard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Alzheimer's Disease Over 5 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medicai use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day 5 ☐ Other (specify) the a 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑ No 24a. Was an certificate has performed? 1 Yes 2 XNo the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide n 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24721 December 22, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Sadiq, MD 14333 Laurel Bowie Road Suite 208 Laurel, Maryland 20708 31. Date filed (Month, Day, Year) **DEC 3 0 2004** 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 25 **Physician** 2004 Helen Delores McKinney 9:58 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2873 Hackney Lane Waldorf Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8 ep. 13, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2∏ F 579-56-0253 60 Yrs \$ep. Wash., Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other treumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director Maryland Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 3405 Glenn Drive 20746 United States 238 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) naturel', or Iteme 11. Marital Status s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1+ Teacher's Aide Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Philip Holman Bessie Samuel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Renee L. Eubanks - Daughter 2873 Hackney Lane, Waldorf, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Important: If iter
any injury or oth 1 Burial 2 Cremation 3 Removal from State Harmony Memorial Park 12/30/2004 4 ☐ Donation 5 ☐ Other (Specify) Landover, MD Stewart Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4001 Benning Rd., N.E. Wash., DC 20019 lugar UMN Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Gause (Final disease or condition resulting in death) Respiratory Arrest Physician /Medical Due to (or as a consequence of): Examiner Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran and The law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year jo Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à aign be 1 Yes 2 No 3 Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 💢 No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 VODaughter's Home ٩ 1 ☐ Yes 2√2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) uneral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death, investigation filled in by the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) efter 4 Homicide 24 hours e 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated. within 2 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) MD 33442 Suite #3-408 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joao Ascensao, M.D. 2150 Pennsylvania Ave., NW Wash., DC 20037 31. Date filed (Month, Day, Year) 2. Registrar's Signature State DEC 3 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 42761 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death December 28 **Physician** Kennith Edward Moorehead 2004 12:22P M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VA Maryland Healthcare System Cecil Perry point 8. Date of Birth (Month, Day, Year)
Aug. 28, 1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1**X** M 2□ F Days Hours 212-26-8309 73 Director 1931 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other treumatic event. It e Madical Examiner must be natified at 1 ☐ Yes 2X No Director Harford Maryland Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23g or 1009 Warwick Drive, Apt 2C 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black à - 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1950-73 "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Importent: if item 27 is marked other then eny injury or other trainment. Elementary/Secondary (0-12) 12 College (1-4or 5+) unknown unknown MOOREHEAD, KENNITH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) North Love Moorehead Margarette East 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geneva Moorehead / wife 1009 Warwick Drive, Apt 2C, Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State R.A. Ferris & Co., Inc * 4 ☐ Donation 5 ☐ Other (Specify) 12/30/04 West Chester, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lisa Scott Funeral Home, P.A. 552 Lewis Street, Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death UNKNOWN Immediate Cause (Final disease or condition resulting in death) Cerebral Vascular Accident - recent **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, attending physician an/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Physici ☐Yes 2☐No detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe . Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Diabetes Mellitus 24a. Was an has autopsy performed? page certificate 1 ☐ Yes 2√ No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) $\stackrel{\circ}{\vdash}$ this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Director: After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide within 24 hours after To the Funerel Dire filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 151094-1 December 28, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melecia Santos, M.D. VA Maryland Healthcare System Perry Point, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 3 0 2004 Registrar

Physician:

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Name known

			1 - For Amend Item 1 State of per Dr Registrer 1 - Decedent's Name (First, Middle, Last) Mer 1	Maryland/Dep .,G839,01/ <i>Ce</i> e Edward Mi	artment of I 3/05dhb <i>rtificate of</i>				4 2 7 6 2
	Physic /Medi Exami	cal	Acrie Edward Market 4a. Facility Name (If not institution, give street and numb			or Location of Death	Month Dec	Day Year 23 200	4 1105 AM
	Funeral		Washington County hospi		Hage	estour, Ma	8. Date of Birth Month, Day 07/15/1	Washing	hplace (State or Foreign
	Director		Usual Residence of Decedent 10a. State 10b. County PA Franklin	10c. City, Town or Lo			07/15/1	932	PA 10d. Inside City Limits 1 □Yes 2公No
	death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number 10819 Church Hill Road		10f. Zip Code	17236	10	g. Citizen of What Co USA	untry?
5-0036	after or Ite	þ	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decede Armed Force 1 ☑ Yes 2 If Yes, Give Year or Date	es? □No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 💆 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
2121		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ing	6b. Kind of Business/ eather man	ufacturing
Maryland	should be fill of Mental H marked ott matic even	To Be	17. Father's Name (First, Middle, Last) George Miller 19a. Informant's Name/Relationship (Type, Print)	1.05.14.11			ye Sevil	le	
-	s 1 and 2 s f Health ar item 27 is other trau		Hazel A. Miller/wife 20a. Method of Disposition 1 🖾 Burial 2 Cremation 3 Removal from Sta	20b. Place of Dispo	Church sition (Name of	Hill Road	, Mercer	oc. Location - City or	17236 Town, State
Baltimore	permit. Page Department o Important: If any Injury or once.		21. Signature of Funeral Service Licensee	Spring Cemet	2. Name and Addre		inger-Fr	emasters, ies Funera urg, PA	PA al Home Inc. 17236
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ž Vi	Physician: r this certifica ral director, I	To Be	examiner? 1 Yes 2 Mo Hospital: 1 Inpa	tient 2 ER/Outpatient	t 3□ DOA Othe	26. Place of Death er: 4 ☐ Nursing Hon		e 6 ☐Other (Speci	fy)
Division o	ttanding P death. ctor: After I the tunera	Certification:	27. Manner of Death 1			Yes 2 □ No	8d. Describe how		
Div	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely tilled in by the tune.	I Certifi	4 Homicide determined 286. Place of 1 building,	njury - At home, farm, stre etc. (Specify)			City or Town, S	· ·	
	To the Hospital within 24 hours a To the Funeral completely tilled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the besix and manner:	or examination and/or inv	estigation, in my op	pinion, death occurre	nd due to the caus d at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
)	o T with	2	29b. Signature and title of certifier Survey, hornedon	11	29c. License			Date signed (Month,	
	3	-	30. Name and address of person who completed cause of	death (Item 23a) (Type, F	Print)	7316		12/23/04	
	Sta	20	Scott M. Kareton, MD. Hoger 31. Date (iled (Month, Day, Year) 32. Regis	death (Item 23a) (Type, F Stron Hexut strar's Signature	1733 Ha	well Reac	1, Hage	istown, it	1e 14/21702
	Registr	(C	JAN 1 3 2005	Is Soul			V	,	/

			1 = For State Registrar	State	of Maryla	and / Depa <i>Ce</i> a	artment of F	lealth and Death	Mental Hy	giene Reg. No		427	163
			1. Decedent's Name (First, Middle, L	.ast)					2. Date of De	aath		3. Time o	of Death
	Physici /Medio		Speros C.	Nits	sios				Month	Day er 2	y Year 6, 2004		n p ^M
	Examin		4a. Facility Name (If not institution, g				4b. City, Town, o	r Location of Deat			. County of De		/
			Holy Cross				Silver S	Spring			Mont	gomery	
	Funeral			Sex		rs. last birthday)		If Under 24 Hrs Hours Min.		rth av. Year)	9. B	Birthplace (State Country)	or Foreign
	Director		578-44-9177	1⊠M 2□F	r	72 Yrs.		1.00.0	Nov. 1			Greece	
	pur &		Usual Residence of Decedent 10a. State 10b. County		100	City, Town or Lo	cation					10d. Inside C	Titu Limite
	sho	7	Tou. State		100.	ony, rown or Ec	oation						2 Mo
	Ba-f	Director	Maryland Montgor	nery		Rockvi							
	with t	吉	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What (Country?	
	a 23	Funeral	11205 Rock Road	10 14/22 [11.5	208				S.A.	dana la dia -	
	er de Itam	nu	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Amed	Decedent Ever in d Forces? es 2 □ No		Was Decedent of H f Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	o-	Black, Wh	merican Indian, hite, etc.	
36	rs aff	by F	3 ☐ Widowed 4 ☐ Divorced	14 3/		3-55	1 ☐ Yes 2 🔼 No	Specify:			Specify:	White	
21215-0036	72 hours after death with the Maryland hatural, or itama 23a or 28a-f show dical Experimer must be notified at	ed	15. Decedent's				dent's Usual Occup	pation		16b. K	ind of Busines	ss/Industry	
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	othe ent,	a	17. Father's Name (First, Middle, La.	st)				18. Mother's Nar	me (First, Middle	, Maiden	Sumame)		
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ary	shor and A s ma		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street				r Town, State	, Zip Code)	
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J.	of He of He Itam		20a. Method of Disposition			. Place of Dispo			Date			or Town, State	
Ĕ	Page 11 2		1 Burial 2 □ Cremation 3 1 Donation 5 □ Other (Spec		_	ate of 1	-	· I	0/2004	Sil:	ver Sni	ring, MD)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 271s marked other than "natural", or Itama 23a or 28a-f show any injury of other traumatic event, Ita Mudical Examiner must be notified at one.		21. Signatore of Financial S	nse	1		. Name and Addre						
m	Pe E E		B. Meich	Hoto	LW CI	/ \ /	1800 New						
	7		23a. Pan1. Enter the disease, or co shock, or heart failure. List on	mplications th	at caused the de	eath. Do not ent	er the mode of dyin	ng, such as cardia	or respiratory a	rrest,		Approximat Interval Bel	te
2	Physician		Immediate Cause (Final disease or condition			Call I	ng Carcin	Om 2				Onset and	Death
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8760,	cate be executed physician and the burial-transit	dlcal		_{d.} Ane	mia	_							
9	# g	Mec	IF FEMALE:						-13-40-74				
Вох	that the death certifi ed by the attending I detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1□Liv	outcome of preg ve birth 2 P	etal death 3 [Ectopic pregnancy	/			23d. Date of d Month		Year
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Sic	tend feath tor: / the f	cat	2 Accident investigat 3 Suicide 6 Could not	he		4		Yes 2 □ No	2011				
Division of	or At	Certification:	4 Homicide determine	289. PI	lace of Injury - A uilding, etc. (Spe	(nome, tarm, str ocify)	eet, lactory, office		City or To			Rural Route Num	nber,
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	Hos 24 ho Funi	lica	29a. Certifier 1 X Certifying I (Check only one) Medical Ex	aminer: On th	e basis of exam	ination and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	e, and due to the arred at the time,	date and	and manner a I place, and du	as stated. ue to the cause(s	5)
	To the Hospital or Attending within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	Medical	29h Signature and title of certifier		nanner stated.		29c. Licens	e number		29d. Dat	le signed (Moi	nth, Dav. Year)	
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	3								MD		•		
	11		30. Name and address of person what 1500 Forest Gler						, M.D.				
	Sta	to.	31. Date filed (Month, Day, Year)		2. Registrar's Sid								
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		1 - For State Registrar	State of Ma	ryland / De		Health and	l Mental Hyg	leg. No2 0 0 1	4 4276
Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, L KENNE I'H 4a. Facility Name (If not institution, g PUNINSULA REGION	O'Co. ive street and number) W NUMCA	NNOR 1 Center	4b. City. Town,	or Location of De	2. Date of Dea Month	Day Yea 27 4c. County of De	4 2017
Funeral Director		5. Social Security Number 6. O10 - 44 - 3705 Usual Residence of Decedent	10M 20F	(In yrs. last birthda Yrs.	Months Days		n. (Month, Day	9. F	Birthplace (State or Fore COUNTY) SSACHUSETTS
the Maryland 28a-fahow Ictified at	ector	10a. State 10b. County DELAWARE SUSSEX		10c. City, Town or OCEAN	VIEW				10d. Inside City Lim
h with	al Dir	10e. Street and Number 6 BRIDLE LANE			10f. Zip Code	970	1	0g. Citizen of What US	Country?
d within 72 hours after death with the Maryland Jene. r than "natural", or Items 23a or 28a-1 ahow It e Macical E.a.: ili serranal be nutified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Milloroced	12. Was Decedent E Armed Forces? 1 Tyes 2 Th If Yes, Give Year or Dates:		3. Was Decedent of If Yes, specify Cul		(Specify Yes or No- erto Rican, etc.)	14. Race - Ar Black, Wi Specify:	nerican Indian, nite, etc. WHITE
75 5 6	Completed	15. Decedent's 6 (Specify only highest g Elementary/Secondary (0-12) 1 2	Education rade completed) College (1-4or 5-	(Gi	cedent's Usual Occu ve kind of work done . DO NOT use retin	upation e during most of we ed)	vorking	16b. Kind of Busines	ss/Industry UFACTURING
ould be Mental arkad c	To Be (17. Father's Name (First, Middle, Las WILLIAM K. O CO	ONNOR			JOAN	ame (First, Middle, M L. MAURE	R	
d 2 s h an 7 ls trau		JOAN O'CONNOR/					Rural Route Number VIEW, DE	City or Town, State	, Zip Code)
permit. Pages 1 and Department of Healt Important: If itam 2 any injury or othar ance.		20a. Method of Disposition 1 Burial 2 Commation 3 i 4 Doparton 5 Other (Spec		20b. Place of Dis cometery, co MELSON S HENEOPEN	position (Name of ematory or other place CAPE CREMATOR	AY 12-	Date	PRANKFORD	
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within 24 hours To the Funaral completely filled	Me	29b. Signature and title of certifler			29c. Licens	se number	29	d. Date signed (Mon	
Sta Registra	-	30. Name and address of person who Howard Gilmer 31. Date filed (Month, Day, Year)	- /00 E. 32. Registrar	Carroll		alisbur	y, MP a	2180/	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item #'s7 and 8 1-7-05/wchd/map Reg. No.2 0 0 4 2. Dete of Death Month 1. Decedent's Name (First, Middle, Last) Year Alberta B. Purnel **Physician** 2004 /Medical 4e Fecility Neme (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Head veers Salisbury If Under 24 Hrs. Nonth, Dev. 28₁₇, 1926 9. Birthplace (State or Foreign Sept. 27, 1927 Maryland If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1□ M 21 F -77 Director 78 212-24-8512 Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health end Mental Hygiene. Int: If them 27 le marked other than "naturel", or items 23s or 28s-f show 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2361 Road 21613 USA Funeral Church Creek 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 Nidowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+)
5 + Board of Education Elementery/Secondary (0-12) Dorchester County Home Economics Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Sarah Bond Oscar Jerome Bishop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4529 Marble Hall Road - Baltimore, MD Barry Purnell/son Depertment of Health Important: If Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran's Cem. 12/29/2004 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21. Signature of Funeral Service License any in JOLLEY MEMORIAL CHAPEL 21801 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Soler the disease, or complications that ceused the shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) momay Examiner Due to (or es a consequence of) Physician/Medicai Examiner certificate has been signed by the ettending physicien and irector, page 2 should be deteched for use as the buriel-transit Physician: The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Dunknown 1 ☐ Yes 2 ☐ No <u>ک</u> 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No ours efter death.

erel Director: After this certificatiled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menser of Death 1 [2Nature] 28b. Time of 28d. Describe how injury occurred Attending 5 Pending 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ö To the Hospital of within 24 hours of To the Funeral D completely filled it Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar (Check only one)

29b. Signature and title of certifier

Inja

31. Dete filed (Month Day, Year) 2004

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

M.D

32. Registrer's Signature

Hwang

PO

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated.

000 16003

29d. Date signed (Month, Day, Year)

Salisbury,

			For State	State of Maryla	ind / Depa		ealth and M	lental Hy	giene	-	42766
			Registrar 1. Decedent's Name (First, Middle, Lasi	0		tinoate of L	, catri	2. Date of De	Reg. No.		3. Time of Death
	Physici /Medi	cal	DOLORES VIOLA PEND 4a. Facility Name (If not institution, give	LETON		4b. City, Town, or	Location of Death	Month 12	Day 23	Year 2004 County of Deeth	9:00 A M
	Examir	ier	3215 SLIMCHANCE LA				SBURY			WICOMIC	0
1	Funeral		5. Social Security Number 6. Se	7. Age (In yi	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da			place (State or Foreign ntry)
	Director		579-38-0406 Usuel Residence of Decedent	□M 2⊠F 7			Hours Min.	06-27-	1931	MARY	LAND
	death with the Maryland ms 23a or 28a-f ahow	<u>_</u>	10a. State 10b. County	10c. (City, Town or Lo	cation					10d. Inside City Limits
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	with the part of 2	급	10e. Street and Number	ਾਹ ਦਾ ਦਾ ਧਾ		10f. Zip Code 218	04		10g. Citiz	en of What Cou USA	ntry?
	eath	era	902 S. DIVISION ST	12. Was Decedent Ever in	U.S. 13.1			ecity Yes or No	h- 1	4. Race - Ameri	can Indian
36	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic avant, the Madical Examiner mast be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give 1 Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2ॣ No		Rican, etc.)		Black, White,	
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215	within 7: ene. then "n	ple	(Specify only highest grad Elementary/Secondary (0-12)	Cotlege (1-4 or 5+)	(Give	kind of work done d DO NOT use retired)	uring most of work	ing			
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Ind	2 should be filed within and Mental Hygiene. Is marked other than sumatic avant, the Ms	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name THELMA KA				
S	ould Men narka natic	9	GUS EDGAR ELGIN	Defeat	405 14 15						0.41
Maryland 21215-0036	d 2 st th and th and than traun		19a. Informant's Name/Relationship (T) TAMMY TOWNSEND - I	•		ig Addrøss <i>(Street a</i> SLIMCHANC					
	Heal Heal tem 2		20a. Method of Disposition		. Place of Dispo	sition (Name of		Date		ation - City or To	
ē	ages ant of nt: If II		1 XBurial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify,	Removal from State	-	natory`or other place L MEM. GD	-	3-2004	HERR	RON, MAR	YI.AND
Baltimore,	permit. Pages 1 and Department of Health Important: If Itam 27 any injury or other tr once.		21. Signature of Funeral Service License			. Name and Address					
ä	Department Department of the suny in concession		* June &	teller							LAND 21804
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	lications that caused the de ne cause on each line.	eth. Do not ent	er the mode of dying	, such as cardiac o	or respiratory ar	rrest,		Approximate Interval Between Onset and Death
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,092	eath certificate be executed attending physician and for use as the burial-transit	cal Examiner	Sequentially list conditions if any, backing to mire dialecture. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conso	equence of):						
89	ificate g phy as the	_		G							
P.O. Box	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23	3d. Date of delive Month	ery Day Year
	ires that signed b		Part II. Other significant conditions co	ntributing to death but not re	esulting in the ur	nderlying cause give	n in Part I.		obacco us		ne cause of death?
Ö	w require	ete	12.7					24a. Was	1		
al Re	sician: The law certificate has b irector, page 2 s	Completed by						autop	rmed?	death?	psy findings available mpletion of cause of
V.	Physician: this certifical	Be c	25. Was case referred to medical examiner?	Hospital:		Other	26. Place of Death				DAUGHTERS
Division of Vital Records,	ding Phy n. After this funeral d	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 2	ne 5 ☐ Resid 28d. Describe h			HOME
Divisi	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre cify)	eet, factory, office		28f. Location (S City or Tox	Street and vn, State)	Number or Rura	il Route Number,
	n 24 hour n 24 hour na Funera	Medical C	29a. Certifying Phy (Check only one) 2 Certifying Phy 2 Medical Exami	rsicien: To the best of my ki iner: On the basis of exami- and manner stated.	nowledge, death nation and/or inv	occurred at the time restigation, in my opi	e, date and place, a mion, death occurre	and due to the o	cause(s) a date and p	nd manner as si place, and due to	tated. o the cause(s)
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•				-2- 12.	O	14000	07 V.7		(a)	20/2	POOY
i	H		30. Name and address of person who co	ompleted cause of death (Ite	эm 23a) (Турө,			DO	/	-/ "	
-	1 ' '		1205 Penters	- Pr. S.		raj w	10	2180	1		
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 8 200	32. Degistrar's Sig	nature &	Sparks	/				

State of Maryland / Department of Health and Mental Hygier (42767 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Painter 8:55 P Orville December 22. 2004 Norman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Davidsonville Crofton Convalescent Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ▲M 2 □ F 75 Yrs Director Aug 6, 1929 Missouri 486-34-7077 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or then "neturel", or Items 23a or 28a-f show the Wedeal Examiner aust be notified at 1 1 Yes 2 □ No Hyattsville Director MD Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20784 U.S.A. 3801 56th Avenue Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give 1947 - 48 Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Brick Mason Construction other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I int: If item 27 is marked o Horace M. Painter Bessie Winfrey ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Davidsonville MD 21035 Diane M. Gainey- Daughter 494 Winding Creek Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department of Important: If any Injury or one Fort Lincoln Cemetery 12/28/04 Brentwood, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityFort Lincoln Funeral Home 3401 Bladensburg Road Erentwood MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op-each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYONIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1□ Yes ZONo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the Hospitel within 24 hours a To the Funerel E 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number nd title of certifier 29b. Signature 7028 12 of person who completed cause of death (Item 23a) (Type, Print) 600 ricle Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 3 0 2004 Registrar

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			Registrar 1. Decedent's Name (First, Middle, Las	t)			timoate or	Doutin	2. Dat	Reg.	No.Z U	3. Tirtie of	6 B
	Physici		Mary M. Prophet						Dec	nth ember	25, 200		Рм
	/Medio Examin		4a. Facility Name (If not institution, give	street and nun	nber)		4b. City, Town, o	or Location of			4c. County of De		
			The Annapolitan As	ssisted	Living	ſ	A	nnapol	is		Anne	Arundel	
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	th the	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of What	Country?	
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9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event, the Medical Examinar must be notified at ance.	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed For 1 ☐ Yes	20100		Was Decedent of I		in? (Specify Ye Puerto Rican,	s or No- etc.)	Black, W		
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	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam	ysicien: To the niner: On the ba and mann	isis of examina	owledge, death tion and/or inv	occurred at the tivestigation, in my	me, date and opinion, death	place, and due h occurred at th	to the cause e time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
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}			Melhae				D	16960	4	1	2-27	7-04	
			30. Name and address of person who			_		^		1	1. 5	/	
			James Chac 31. Date filed (Month, Day, Year)		So 9 Bistrar's Signa	Kitc	thie Hu	YA	, nue (2, '	M17 3	21012	
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				State of Marylar	nd / Dep		f Health and	Mental Hy	giene nn	L 12760
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) Frank J. Ross Aa. Pacility Name (If not institution, one si	treet and number)	ical Cen		n, ortocation of Deat	2. Date of De Month	_	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. M 2□F 80	last birthday) Yrs.	If Under 1 Ye Months Da			th ly, Year) 924	Birthplace (State or Foreign Country) DE •
	Ba-f show	Director	10a. State 10b. County DE SUSSEX		ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Exam national be notified at once.	by Funeral	10e. Street and Number 14292 Pepperbox 11. Marital Status 1 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	Road 2. Was Decedent Ever in U Armed Forces? 1 Yes 2 M No If Yes, Give Year or Dates:	.S. 13.		940 of Hispanic Origin? (S Cuban, Mexican, Puen	specify Yes or No to Rican, etc.)	USA - 14. Race - Black, 1 Specify:	at Country? American Indian, White, etc. White
0-61212	i within 72 ho liene. r than "natur. The Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use re	cupation ne during most of wo tired)	rking	16b. Kind of Busin	•
ylarıdı	2 should be filed and Mental Hyg Is marked other raumatic event,	To Be C	17. Father's Name (First, Middle, Last) Tony Ross				Christi	na DiTom	Maiden Surmarne) ness Ross	
e E	1 and 2 sh Health and tem 27 Is rr		19a. Informant's Name/Relationship (Typ Dave Ross, Son 20a. Method of Disposition		14348		rbox Rd.)
Dallimor	permit. Pages Department of Important: If it any injury or o		1	St	. Stepl	hens Cer	n. Park 12		Delmar,	
	English of the state of the sta		23a. Part1. Enter the disease, or complic shock, or headrailure. List only one Immediate Cause (Final disease or condition	rations that caused the deal		13 E. (Delmar.	De. 19940	Approximate Interval Between Onset and Death
,00,	Windpures that the death centilicate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the to	uence of).	11-	HOUIÀ FOOK			3 Dus
O. DOX 0	to the hospital of Attending Priystcian: within 24 hours after death. To the Fundual Director. After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregnant 1 Live birth 2 Feta 4 Pregnant at time of c	ıldeath 3[Ectopic pregna Other (specify			23d. Date of Month	f delivery Day Year
ecolus, r	aquires tnat en signed b ould be deta	þ	Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	nderlying cause	given in Part I.		obacco use contribu	te to the cause of death? Probably
אוומו חפכי	an: The Taw Fr liticate has be or, page 2 sh	e Completed	25. Was case referred to medical				26 Place of Doc		prior deat	
	ding rnysician: the lay h. h. After this certiticate has funeral director, page 2	tlon; To B	examiner?	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	f 28c. In	Other: 4 Nursing Hardy at Nork?	ome 5 🗆 Resid		Specify)
DIVISI	To the Hospital of Attends within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Płace of Injury - At h building, etc. (Specif	ome, farm, str	-		28f. Location (5 City or Ton		r Rural Route Number,
	tne nospi hin 24 hour the Funer npletely fill	Medical	one)	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or in	vestigation, in m	y opinion, death occu	rred at the time, o	date and place, and	due to the cause(s)
ı	00 T wit	4		oundre		7	32014		29d. Date signed (M	,
1	Sta	te	30. Name and address of person who com MAN 1-7 M MOO 31. Date filed (Month, Pay, Year)	npleted cause of death (Iter N DR A 0 32. Regisfrar's Signa	n 23a) (Type, Mil)	Print)	SK- 504	B Salis	1301-10	nd Usoq
	Sta Registr		31. Date filed (Month, DEC 2 8 2	32. Registrar's Signa		1 Spi	uks			

State of Maryland / Department of Health and Mental Hygienery Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CLIFFORD SMITH DEC. 27 2004 7:10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner BERLIN NURSING & REHABILITATION CTR. BERLIN WORCESTER If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) OCT 15, 1915 6. Sex 1.XM 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** MARYLAND 89 Director 221-10-1747 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Exerciser must be notified at 1 Yes 2 □ No Director MARYLAND WORCESTER WHALEYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21872 8113 CIRCLE ROAD USA death v Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or Iter ury or other traumatic event, Ite Medical Executer 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 🛣 No Specify: Specify: 3 □ Widowed 4 ☒ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BARBER HAIR 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **MCFADDEN** SMITH LUCY **JONES** ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEFFREY J. SMITH SR./SON 34836 OLD OCEAN CITY ROAD, PITTSVILLE, MD 21850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete permit. Pages 1 Department of H Important: If Ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ALL SAINTS' CEMETERY 12/30/04 ANGOLA, DELAWARE * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility u HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 steel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Par /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Earle, Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Box 68760. Medical Certification: To Be Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached P.0. 9 Unknown 9 Unknown signed be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24e. Was an page 2 autopsy performed? 1 ☐ Yes 2 1NO Division of Vital in by the funeral director, 25. Was case referred to medical examiner? 26. Place o ath Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20100 1 Inpatient 2 ER/Outpatient 1 Yes 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pendina investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Diractor: / 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number C1-0006795 ed cause of death (Item 23a) (Type, Print) COASTAL HIGHWAY, FENWICK TSLAND, RE, 9944 1209 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 03 2005

ORIGINAL

		1 - For State Registrar	State of Maryla		artment of F		nd Mental Hy		0.1	
		Decedent's Name (First, Middle, Last,				Douin	2. Date of De	Reg. No	U-4	3. Firme of Death
Physici /Medi		David Nola	an Smit	h			Oct.	Jay .	2004	1050 M
Examir		4a, Facility Name (If not institution, give		0 .	4b. City, Town, o	r Location of		4c. Coun	ty of Death	,,,,,
		Peninsula Region	al Medicor	Center	Valle	strey	,	W	come	ف
Funeral		5. Social Security Number 6. Sec			If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bi			ace (State or Foreign
Director		332-98-6517	M 2∐F 50	Yrs.	34,5	110013	Min. 8. Date of Bi (Month, Date of All 1/7/19	54	unkr	nown
and		Usual Residence of Decedent 10a. State 10b. County	10c. G	ity, Town or Lo	ocation				10	id Inside City Limits
danyl f sho	ច	Louisiana Orlean								d. Inside City Limits 1 XYes 2 □ No
the 288-	rect	10e. Street and Number	5 INE	w Orle	10f, Zip Code			10g. Citizen of	E Milhot Count	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ance.	0	4311 Werner Drive			70126	5		USA	What Count	iyi
death ms 2	Funeral Directo		12. Was Decedent Ever in t	J.S. 13.			n? (Specify Yes or No Puerto Rican, etc.)		ace - America	n Indian.
or ite		Never Married 2☐ Married	Armed Forces? M☐Yes 2☐No				Puerto Rican, etc.)		ack, White, et	
ours iral', Era	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: Navy		1 ☐ Yes 2 🛣 No	Specify:		Speci	ify:	white
natu	Completed	15. Decedent's Edu (Specify only highest grade	cation co <i>mpleted)</i>	(Give	dent's Usual Occup kind of work done	durina most o	f working	16b. Kind of	Business/Indu	ustry
MITTING SOB. Than	m	Elementary/Secondary (0-12) unknown	College (1-4or 5+)		DO NOT use retired	,		D		
Hygie ther int,		17. Father's Name (First, Middle, Last)	unknown	Merc	hant Mari		Name (First, Middle	Baypo		
red o	Be c	David Smith						, waloen Suma	me)	
mark mati	ှင	19a. Informant's Name/Relationship (Ty	oe. Print)	19b Mailie	ng Address (Street		nown or Rural Route Numb	or City or Tour	Stato Zin (Pada)
Ith ar 27 is r trau		R. Clarke Britting	•				ane, Long			
f Hea f Hea item othe		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of matory or other place	LOCK I	Date	20c. Location		
Page ento nt: # ry or		1 ☐ Burial 2 【XCremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	amovarmont State	_	cremator	1	2/27/04	Coliaba	10T	
oartm Sorta		21. Signature of Funeral Service License		22	2. Name and Addres	ss of Facility		Salisbu		
Depar Impou		1 avis 44. 1800	LOON CFS	SP 50	olloway F	uneral	Home Prof Salisbur	essiona	ASSC	ciation
1969 II		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	critions that caused the dea		er the mode of dyin	ng, such as ca	rdiac or respiratory a	rrest,	A	Approximate
Physician		Immediate Cause (Final disease or condition	SEP.	5 16						nterval Between Onset and Death
/Medical		resulting in death)	Due to (or as a consec							
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atter I for u	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	aldeath 3□	Ectopic pregnancy Other (specify)			1	ate of delivery onth Da	ay Year
by the	Physician/Me	1 Yes 2 No 9 Unknown	9□ Unknown							
igned by the attendin be detached for use	by Pł	Part II. Other significant conditions con	tributing to death but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use con	tribute to the	cause of death?
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s been s should	oiet						24a. Was	an 24b.	Were autops	v findings available
page 2	Completed							rmed?	death?	y findings available pletion of cause of
certificate ector, pag	O	25. Was case referred to medical				26 Place of	1 ☐ Yes Death (Check only of	1	1 ☐ Yes 2	□ No
S P	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 X Inpatient 2	ER/Outpatien	t 3 DOA Othe		ng Home 5 Resid		ner (Specify)	
After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	/ at	28d. Describe	now injury occur	red	
or: Al	atic	2 Accident investigation	,, _a,,	jury		Yes 2□No				
within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre	eet, factory, office		28f. Location (S City or Tox	Street and Numb	er or Rural R	Route Number,
oral D	O	<u> </u>					1			
Fune Fune tely fi	edical	(Oneck only 2 Medical Examin	ician: To the best of my kno	owledge, death	occurred at the time	ne, date and pointion, death o	lace, and due to the	cause(s) and ma	anner as state	ed. ne cause(s)
mplei	Med	one) 29b. Signature and title of certifier	and manner stated.							
₽ 8					29c. License			29d. Date signe		
A		white 30 No.			04	7094		12/26	104	
		30. Name and address of person who con		n 23a) (Type, I	Print) N STOZETE	7 5	ters Bury	MD 2	1804.	,
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa							
Registr		DEC 9 9 200		. 4	Aca. w	1				

DHMH 17 Rev 1/2001

DAVID SMITH 552-98-6517

			For State Registrar	State of Ma	aryland /		rtment of F			iene •g. No.	2004	4277
	Physici	an	Decedent's Name (First, Middle	, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
	/Media	al	Theresa	E. Strange					Decembe	_	4, 2004	11:00 Рм
	Examir	ier	4e. Fecility Name (If not institution					r Location of Death	1		County of Deeth	
	Europal		Prince Georges 5. Social Security Number		e (in yrs. last i	birthday)	Cheve If Under 1 Year		8. Date of Birth		ince Geo	
	Funeral Director		578-32-0265	1 □ M 2 🖾 F	86	Yrs.	Months Days	Hours Min.	July 4,	Year)	L8 Wash:	lace (Stete or Foreign try) ington DC
	D		Usual Residence of Decedent 10a. State 10b. County		10- City T							
	shov	5			10c. City, To						1	0d. Inside City Limits 11 Yes 2 □ No
	28a-f	Director	MD Princ 10e. Street and Number	e Georges		For	restville	9		On Citiz	en of What Coun	
	death with the Maryland rms 23a or 28a-f show rmust be notified at	0	1302 Wendo	ver Court				747		-	U.S.A.	uy:
	ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. V	Vas Decedent of H	lispanic Origin? (S	pecify Yes or No-		4. Race - Americ	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. I fleath and Mental Hygiene them 23a or 28a-f show other traumatic event, the Medical Exametre must be notified at	þ	1 ☐ Never Married 2 ☐ Marr 3 🙀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ f If Yes, Give Year or Dates:	No		Yes 2X No	an, Mexican, Puert Specify:	o Alcan, etc.)		Black, White, Specify: Bla	
, C	72 h	Completed	15. Decedent (Specify only highes	's Education t grade completed)	16	(Give	ent's Usual Occup	during most of war	king	16b. Kin	nd of Business/Inc	dustry
7	within nne. han	ш	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. E	OO NOT use retired Clerk	d)		C.		
7	filed y	e Co	17. Father's Name (First, Middle,	Last)			CIEIK	18. Mother's Nan	ne (First, Middle, i		overnmen	τ
yland	d be antal	00		Harrison					v Eva Har		,	
<u> </u>	shoul nd Ma mari mari	2	19a. Informant's Name/Relations		1	9b. Mailin	g Address (Street	and Number or Ru				Code)
Ma	t and 2 Health a tem 27 te		Edgar H. Thom	as- Son	1	302	Wendover	Court I	orestvil	le 1	MD 2074	7
ē,	of Head		20a. Method of Disposition	2	20b. Place	of Dispos	sition (Name of natory or other place	ce)	Date	20c. Loc	cation - City or To	wn, State
Ĕ	Peges nent of I ant: If It ury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		Fort		oln Ceme				twood, M	
Baitimol	permit. Peges Depertment of the Importent: # Ite eny injury or of once.		21. Signature of Funeral S	Licensee				ss of Facility Fo				
_	70 E 9 9		23a. Part1. Enter the disease, or shock, or heart failure. List					ensburg			d MD 207	22 Approximate
	Medical by Medical Med	al Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence	ce of):		N) 0-45	wir b	12-2	ase i	
000	icate phys s the	dical		d								
)	uires that the death certifi isigned by the attending to Id be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ¶o 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetel dea		Ectopic pregnancy Other (specify)	,		2:	3d. Date of delive Month	ry Day Year
ν L	law requires that as been signed b 2 should be deta	by P	Part II. Other significant condition	ens contributing to death b	ut not resulting	g in the un	iderlying cause giv	en in Part I.	23a. Did tol	acco us	se contribute to th	e cause of death?
cords	v require been sig should b		Cenebralin	Farct 0-					1 □ Ye	s 2[No 3 Proba	abiy 4 🖯 Onknown
Ē	The law rate has be page 2 sh	Completed	Respiratory	failure					24a. Was a autops perform	y ned?	24b. Were autop prior to con death? 1 \(\sum \) Yes	osy findings available noletion of cause of
	Physician: The this certificate har all director, page	Be (25. Was case referred to medical examiner?						th (Check only on	e)		
5	Physion this calding	ို	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie		Outpatien		4 Nutsing n	ome 5 Reside)
DIVISION	Attending Physical Corrections of the Correction	Certification:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could re	ation	y Year)	o. Time of Injury		yat k? Yes 2 □ No	28d. Describe ho	w injury	occurred	
2	Hospitel or Attending 4 hours after death. Funerel Director: After tely filled in by the fune		4 Homicide determ	ined 286. Place of Inj building, et					City or Towr	, State)	Number or Rural	
	the the	Aedical	one) 2 Medical	g Physician: To the best Examiner: On the basis of and manner sta	f examination	lge, death and/or inv	estigation, in my o	pinion, death occu	rred at the time, d	ate and	place, and due to	the cause(s)
	P IN CO	2	29b. Signature and title of certified	. / /	ean	2	29c. Licens	<u> </u>			signed (Month, E	*
_	(7)		Name and address of person	who completed cause of d	leath (Item 23a	a) (Type, I	Print) Jeeust	1552	Hyallo	ا، ن	- KUS	20131
	Sta Registi	rar	DEC 3 0 20	a. Hogisti	ar o orginatoro	from	E .	(·		
DHA	H 17 Rev 1/2	001		÷	4							

			For State Registrar			State	of Mar	yland / I		rtment tificate			nd Me	_	giene	000	11.	1.2772
	Physicia /Medic		1. Decedent's Name WALTER S3											2. Date of De Month DECEMB	ath		004	3. Time of Death 6:00 a M
	Examin		4a. Facility Name (I			treet and n	ımbər)			4b. City, To		Location of I	Death		4c.	County o	f Death	I
	Funeral Director		5. Social Security N 007-09-69	umber	6. Sex	M 2□F		In yrs. last bii 7	rthday) Yrs.	If Under 1 Months [Year Days	If Under 24 Hours	Hrs. Min.	8. Date of Bir (Month, Da MARCH	th 1 <i>y</i> , Year) 3, 1	917	9. Birthp Coun U • S	lace (State or Foreign try) NEW •A• YORK
	Maryland -1 show fied at	tor	Usual Residence of 10a. State MD	10b. County MONTGO		7		OCKVII		cation							1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28a ist be noti	<u>a</u>	10e. Street and Nur 6121 MON3	nber						10f. Zip C					10g. Citi	en of Wh	nat Coun	try?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I firant 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, I'm Medical Evantmer must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	_	ried	2. Was De Armed F 1X Yes If Yes, G Year or	orces? 2 □ No			Vas Deceder Yes, specifi X □ Yes 2		spanic Origin n, Mexican, F Specify:	? (Spec Puerto R	ify Yes or No ican, etc.)	-	14. Race Black, Specify:	White,	etc.
Baltimore, Maryland 21215-0036	nin 72 hour In "natural Medical E	Completed		15. Deceden	nt's Educ	ation completed			(Give	lent's Usual (kind of work OO NOT use	done di	lunna most o	f working	7	16b. Ki	nd of Bus		
nd 212	be filed with	Be	17. Father's Name	(First, Middle,	Last)	5+			ENT	ATTOR		18. Mother's		First, Middle,		• GO\ Sumame,		MENT
Maryla	h and Men r is marke raumatic	၉	PAUL STOI 19a. Informant's Na FREDA BAI	ame/Relations	ship <i>(Typ</i>	e, Print)				-	Street a		or Aurai	KMAN Route Numbe GAITH				,
nore, l	ages 1 and nt of Healtl t: If itam 2 7 or other 1		20a. Method of Disp	oosition Cremation		emoval from		20b. Place o cemete	f Dispos	sition (Name natory or othe	of er place	9)	Da	te	20c. Lo	cation - C	ity or To	wn, State
Baltin	permit. P Departme Importan any injury	1	` 4 □ Donation 21. Store une of Fu	COLUMN TO SERVICE	LI (I)	M		NATION	22	. Name and	Address	s of Facility	NAT	/2005 [IONAL LLS CH	FUNE	RAL I	HOME	
	Physician /Medical		23a. Part1. Enter the shock, or heal immediate Cause disease or condition resulting in death)	Final	complic only one		PN	EUM	not ente	er the mode of						, ,,,,		Approximate Interval Between Onset and Death
- 1	ite be executed with the purial-transit and t	dicai Examiner	Sequentially list co if any, reading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	riying - injury	b. c. d.	Dusto	SE (c) as a	Consequence	of).	SHOC	K							
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066 rds, P.	es be		Part II. Other signif	icant condition	ons cont	ributing to	death but	not resulting i	n the un	nderlying cau	se give	n in Part I.		23e. Did to	5			e cause of death?
JANG P	The law ate has b page 2 sl	Completed											-	24a. Was autop perfo 1 Yes	rmed?	pride	or to con ath?	sy findings available pletion of cause of
STOLL death on of Vital	Phys this ral dii	To Be	25. Was case refer examiner? 1 Yes 2 2 27. Manner of Den 1 Natural	No 5 □ Pendir	Ho	ospital: 1 X	Inpatient f Injury nth, Day	28b.	utpatient Time of Injury	3 □ DOA 28c	Other	r: 4 □ Nursi	ng Home	Check only on 5 Resided. Describe h	dence 6)
13 15	or Atten after deat Diractor: in by the	Certification:	2 Accident 3 Suicide 4 Homicide	investi 6 Could determ	not be	28e. Plac build	e of Injury ling, etc. (r - At home, fa (Specify)	ırm, stre			65 2 100	-	f. Location (S City or Tox			or Rural	Route Number,
A VI	e Fur ho	Medical C	29a. Certifier (Check only one)	1 Cartifyir 2 Madical	ng Physi Examin	ar: On the	e best of a pasis of ea oner state	my knowledge xamination an d.	e, death	occurred at estigation, in	the time my opi	e, date and p inion, death	olace, an	d due to the	cause(s) date and	and mann place, and	er as sta d due to	ated. the cause(s)
	To tha within 2 To tha complet	Σ	29b. Signature and	title of certifie		sucul	-	M.D	0	Ī) -	number 27 6			10	e signed (4/0	4
CR (7)		30. Name and addr	al Gos	YUA	MI I	7 - D .	th (Item 23a)	(Type, F	Print) ROCKU	11 LL	E PI	KE	RU,	MI)20	85	2
	Sta Registra	-	31. Date filed (Mon	th, Day, Year)		Bea	negistrar's	s Signature	free	W								

			1 - For S Registrar	tate of Maryla		artment of I		nd Mental Hy	giene 004	42774		
			Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death		
	Physici /Medic		Dolores L. Smerz					Month Decembe	er 24 200			
	Examir		4a. Facility Name (If not institution, give street			4b. City, Town, o		Death	4c. County of D	eath		
			12113 McDonald Chap			Gaither		****	Montgom			
I	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	2 X F 7. Age (In yo	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of Bin (Month, Da Feb 1,	1914 9.1 1914 N	Birthplace (State or Foreign Country)		
	pur 🔏		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	postion				101 1-11-01-11-11-11-11-11-11-11-11-11-11-11		
	f sho	ō								10d. Inside City Limits 1 ☐ Yes 2 🗓 No		
	28a-1	Director	MD Montgomery 10e. Street and Number	7		Gaithers 10f. Zip Code	burg		10g. Citizen of What			
	with 3a or 1 be	Ö	12113 McDonald Cha	nal Driva			20878			nited States		
	death ms 2;	Funeral	11. Marital Status 12.	Was Decedent Ever in	U.S. 13.			in? (Specify Yes or No Puerto Rican, etc.)		mencan Indian,		
9	or Ita	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give				Puerto Rican, etc.)				
93	ral',	d by	3 Widowed 4 □ Divorced	Year or Dates:		1 ☐ Yes 2XINo	<i>Specify:</i>		Specify:	White		
5-(within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show ta Mailcal Examiliar is ust be tricitified at	Completed	15. Decedent's Education (Specify only highest grade co	mpleted)	(Give	dent's Usual Occup kind of work done	during most	of working	16b. Kind of Busine	ss/Industry		
12	withir ene. than	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire cutive S	,	3037	Investmer	+ Prolear		
g 5	filed Hygi othar ent, I		17. Father's Name (First, Middle, Last)		LAC	cacive 5		's Name (First, Middle,		it broker		
lan	lid be lental kad c	To Be	Frank Landzettel					Waters	,			
ary	and N s mai	_	19a. Informant's Name/Relationship (Type,					or Rural Route Number				
Σ,	and 2 salth n 27 i		Judith S. Sholes/Dau	ighter	12113	McDonal	d Chap	el Drive,	Gaithersbu	irg, MD 20878		
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Remo	20b	. Place of Dispo	sition <i>(Name of</i> natory or other pla C an	ce) D	Pate ecember	20c. Location - City	or Town, State		
Ë	trant:		`4 □Donation 5 □ Other (Specify)		Crèmat	ory	2	ecember 8, 2004		a, Virginia		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy hipty or other traumatic event, if a M. Lical Ex., iller is as the reliffed at once.		21. Signature of Forlieral Service Locations 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877									
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications of the complex control of the control of the	ons that caused the de ause on each line.	eath. Do not ent	er the mode of dyi	ng, such as c	ardiac or respiratory ar	rest,	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition resulting in death)	C	ongesti	ve Heart	Failu	re		Onset and Death Years		
	/Medical Examiner		resulting in death)	Due to (or as a cons								
		P.	Sequentially list conditions, b. —	Due to (or as a cons		Artery	Diseas	e		Years		
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
ó	exec an an rial-tra	Еха	resulting in death) Last Due to (or as a consequence of):									
8760,	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	d									
9	ing ph	Med	IF FEMALE:									
Вох	eath certific attending p for use as	ian/l	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of preg 1□Live birth 2□Fe	etal death 3	Ectopic pregnancy	,		23d. Date of o	delivery Day Year		
o.	the a	Physician/Me	1 Ves 2 XNo	4⊟Pregnant at time o 9⊟ Unknown	f death 5□	Other (specify) _			World	Day 1 bai		
Δ.	that the de ed by the a detached t	Ph	Part II. Other significant conditions contrib	uting to death but not r	esulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	obacco use contribute	to the cause of death?		
Vital Records,	uires the signed Id be de	d by	Pennicious Anemia			, ,				Probably 4 Unknown		
COL	w requir been si should	iete	Restrictive Lung D	isease				24a. Was	an 24b Were	autopsy findings available		
Re	The lav	Completed	Goiter	Iscasc				autop	sy prior t rred? death	o completion of cause of ?		
ta		BeC	25. Was case referred to medical				26. Place o	1 ☐ Yes of Death Check on o		es 2 No		
	S S = D	ToB	examiner? 1 ☐ Yes 2 🔀 No Hosp	ital: 1 ☐ Inpatient 2	ER/Outpatien	t 3 DOA Oth	oc	sing Home 5 XResid		pecify)		
0 [Attanding Physician: r death. actor: After this certific by the funeral director,		27. Manner of Death 2 1 X Natural 5 ☐ Pending	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at		ow injury occurred			
Sio	andii eath. or: A the fu	catio	2 Accident investigation				Yes 2 □ No	0				
Division of	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 2	 Place of Injury - At building, etc. (Spe 	home, farm, stre cify)	eet, factory, office		28f. Location (S City or Tow	Street and Number or m, State)	Rural Route Number,		
נ	To the Mospital or Attanding Phywithin 24 hours after death. To the Funeral Diractor: After thi completely filled in by the funeral o		29a. Certifier 1X Certifying Physicie	m. To the heat of	noudad 1			-1				
	24 hc 24 hc Fun etely	Medicai	(Check only 2 Medicel Examiner:	On the basis of exami and manner stated.	nowledge, death nation and/or inv	estigation, in my c	ne, date and pinion, death	place, and due to the o noccurred at the time, o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1.0 /	7	29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)		
•	1		· A - M	4. 11	/	D3519	92		December	27, 2004		
	5		30. Name and address of person who comple									
			Kevin Gil M.D., 148	1		e #253, I	Rockvi	11e, MD 208	350			
	Sta Registr		31. Date filed (Month, Day, Year) PEC 2 9 2004	32. Registrar's Sig	nature	Sparks	/					

neets, Mand

			Please T	ype or Print in Bla State of Maryland				-	•		
			1 = For State Registrar	olate of Marylana /		ificate of E		Reg. N	2001.	42775	
d	Physici	an	Decedent's Name (First, Middle, Last)					ate of Death	ay Year	3. Time of Death	
	/Media	cal		E. She			De	c. 27,	2004	13:05P M	
	Examir	ier	4a. Facility Name (If not institution, give s	treet and number)	1	4b. City, Town, or		4	c. County of Death		
	Funeral		Union Hospital 5. Social Security Number 6. Sex	3.1		Elkton If Under 1 Year Months Days	If Under 24 Hrs. 8, Da	ate of Birth fonth, Day, Yea	Cecil 9. Birthp	lace (State or Foreign	
F	Director		194-20-9018 Usual Residence of Decedent	M 2X)F 79	Yrs.	violitis Days	Fel		1925	TN	
	yland		10a. State 10b. County	10c. City, To	own or Loca	tion		- <u> </u>	1	0d. Inside City Limits	
	a-fat	cto	Maryland Cecil	Perr	yvill	Le				1 ☐ Yes 2X No	
	72 hours after death with the Maryland natural', or items 23a or 28a-f ahow Jical Exaction Transt ke nuffilied at	Directo	10e. Street and Number			10f. Zip Code		10g. C	Citizen of What Cour	ntry?	
	ns 234	eral	408 Concord Dri	V C 2. Was Decedent Ever in U.S.	13 Wa	2190			ited Sta		
٥	ours after deal	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo			panic Origin? (Specify Y , Mexican, Puerto Rican	, etc.)	Black, White,		
2-003 6	"natural",	d by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		Yes 2⊠No	Specify:		Specify: Wh	nite	
<u>ဂ</u>	in 72 ho "natur	Completed by Funeral	15. Decedent's Educ (Specify only highest grade	completed)	(Give kir	nt's Usual Occupa nd of work done do NOT use retired)	tion uring most of working	16b.	Kind of Business/Inc	dustry	
717	d within giene. er than "	omi	Elementary/Secondary (0-12)	College (1-4or 5+)	Home	emaker			Home		
and	be filed tal Hygie d other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (First	, Middle, Maide	en Sumame)		
\geq	hould d Mer marke matic	10	Raymond Ray 19a. Informant's Name/Relationship (Typ.	an Reint)	Ob. Mailine	Address (Street a	Clarris V		ers r, City or Town, State, Zip Code)		
<u>B</u>	and 2 sho ealth and n 27 Is mu iar traum		Linda Daddezio		_		rg Rd, Lar			1	
e,	一工商品		20a. Method of Disposition	20b. Place	of Disnosit	ion (Name of tory or other place	Date	20c. I	Location - City or To		
aitimor	permit. Pages Department of Important: If it any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	Unio			et.Dec. 31	L,04 K	ennett S PA	Square	
gan	Depart mport mport any in		21. Signatur of Furieral Service Li	hat agous		iame and Address	CIEVE		& Gofus		
			23a. Part1. Enter the disease, or complic	cations that caused the death. D			enna. Ave. such as cardiac or resp		dale, PA	Approximate	
	Pnysician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	Λ	no S	a breation	м		1	Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequence	ce of):	- 4	n Disæse			enknown Cenknown	
	- Adminier	<u>5</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence		e Mart	Visause			unknown	
P	executed in and ial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events		,						
0	oe executed cian and ourial-transit	Exa	resulting in death) Last	Due to (or as a consequence	oe of):						
9/89		dica	d.								
g x o	death certificate be ex e attending physician od for use as the burial	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy					23d. Date of delive	rv.	
	death le atte	icia	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		ctopic pregnancy Other (s <i>pecify)</i>				Day Year	
r S	that the de led by the a detached i	Phys	9 🗆 Unknown		- I - Maria - I			0. 0:14		41.40	
	w requires that been signed to should be deta	by	Part II. Other significant conditions confi		g in the unde	ariying cause giver	nin Parti. 2		use contribute to th		
ecords	faw requasi been 2 should	Completed	- Cona 0 -	Cay C			20	4a. Was an		osy findings available	
T T	has has	ошр						autopsy performed?	prior to cor death?	npletion of cause of	
	yaician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?				26. Place of Death (Che		0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2010	
5	hys this ai di	2	1 ☐ Yes 2 ☐ No	and the second s	Outpatient	3□ DOA Other	4 Nursing Home 5)	
50	al or Attending F s after death. I Director: After d in by the funera	Certification:	27. Manper of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	o. Time of Injury	28c. Injury : Work? M 1 \(\text{Y}\)	at 28d.D es 2∐No	escribe how inj	nry occurred		
DIVISION	er dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street	t, factory, office			and Number or Rura.	Route Number,	
5	oital or urs aft ral Dir lled in							ty or Town, Sta			
	To tha Hospital or A within 24 hours after To tha Funaral Direc completely filled in by	edical	29a. Certifier 1 ✓ Certifying Phys. (Check only one) 2 ☐ Medical Examin	ician: To the best of my knowled er: On the basis of examination and manner stated.	lge, death o and/or inves	ccurred at the time stigation, in my opi	, date and place, and du nion, death occurred at ti	e to the cause(: he time, date ar	s) and manner as st nd place, and due to	ated. the cause(s)	
	To the within To the comple	Me	29b. Signature and title of Prtifier			29c. License		29d. D	ate signed (Month, I	Day, Year)	
) Vaeled	er s nu		100	23322		12.28.0	2004	

State Registrar

4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. S. ACHDEN MD / ICNORTH St Science 3B, E-Chiten MD 2/92/,

31. Date filed (Manyler Day, gear) 2004

32. Registrar's Signature

			1 - For State Registrar	State of Maryla	_	artment of F tificate of		lental Hygie	711113	42776
	Physici /Medio		1. Decedent's Name (First, Middle, Last) $Everett$		Spri	ggs		2. Date of Death Month Decembe	Day Year r 26,20(3. Time of Death 04 9:27 P M
	Examir		4a. Facility Name (If not institution, give s 521 W. McKendre			4b. City, Town, o Dunl	Location of Death		4c. County of Dea	
	Funeral Director			7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes	9. Bir 1938 Mai	thplace (State or Foreign buntry) Yland
	daryland f show	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Anne An		City, Town or Lo	cation Dunkii				10d. Inside City Limits 1 ☐ Yes 2 🏋 No
	with the ? 3e or 28e-	Directo	10e. Street and Number 521 W. McKend			10f. Zip Code)754	10g.	g. Citizen of What Country?	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic evant, the Marittal Exertainal must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in Amed Forces? 1 ☐ Wes 2 ☐ No If Yes, Give Year or Dates:	1	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spo un, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: B1	
21215-0036	i within 72 ho iene. rthan "natu the Medicul	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1.2	cation completed) College (1-4or 5+)	life. L	lent's Usual Occup kind of work done o DO NOT use retired	work done during most of working T use retired)		Constru	,
Maryland 2	should be fited and Mental Hygis marked other umatic evant, Il	To Be Co	17. Father's Name (First, Middle, Last) Ellsworth	Sp	riggs	Препред		e (First, Middle, Maid		
. –	1 and 2 shot Health and N am 27 is ma ither trauma		19a. Informant's Name/Relationship (Tyg Valerie Spriggs		19b. Mailin 521 V	g Address (Street A. McKer	and Number or Rura ndree Rd	al Route Number, Ci • Dunk	ity or Town, State, 2 Kirk, MI	
Baltimore,	F F F F		20a. Method of Disposition 1 □ MBurial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	emoval from State S p	riggs	natory`or other plac Cemeter	y 12/3	0/04 I	unkirk,	MD
Ba	permit. Departn Importe eny inju		Bladep a. L	levell						ome d.,MD20678
	Pnysician /Medical Examiner	_	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	PHDW duence of):	A	g, such as cardiac c	r respiratory arrest,		Approximate Interval Between Onset and Death
68760,	ficate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
P.O. Box 6	law requires that the death certificate been signed by the attending to should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cause give	en in Part I.	23e. Did tobacc	20 use contribute to	the cause of death?
Vital Records,	The ate h page	Completed			-			24a. Was an autopsy performed 1 Yes 2	prior to d	topsy findings available completion of cause of
Division of Vita	Attanding Physician: The relath. actor: After this certificate by the funeral director, pag	Certification: To Be	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ospital: 1 Inpatient 2 [28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At I	28b. Time of Injury	28c. Injury Work M 1 🗆 Y	4 Nursing Hor		njury occurred	
Οįς	spital or Attan ours after deall naral Diractor: filled in by the		4 Homicide determined 29a. Certifier 1 Sertifying Phys	building, etc. (Spec	ify)			City or Town, St	tate)	
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medicel Examirone) 29b. Signature and title of certifier	er: On the basis of examin and manner stated.	ation and/or inv	estigation, in my op	pinion, death occurre	ed at the time, date a	and place, and due	to the cause(s)
	-11		30. Name and address of person who co	mpleted cape of death (Ite	eq 23 (Type, F	Print)	364	17	2/28/201	121
	かり Sta	te	31. Date filed (Month, Day, Year)	32. Registrats Sign	DK(S)	MUE!	21)300 P	MARKER	2 MD S	1401
	Registr	ar	DEC 2 9	2004 Beneu	w St.	sperke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere [] [] [] 1 - For State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Vivian Marie Holden Schnabel /Medical December 21, 2004 9:50 P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Sunrise Assisted Living Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🛣 F Yrs Director 503-01-4296 87 12-11-1917 South Dakota Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23s or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Anne Arundel Edgewater 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours efter death with 130 Seahawk Lane 21037 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Be Completed by 3℃Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) years Homemaker Home of Health and Mental Hyges: If Item 27 is marked other or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be f nent of Health and Mental I ent: If Item 27 is marked o Howard Holden Verba Lund ျ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 Seahawk Lane, Edjewater, MD 21037 Linda S. Vogan/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department o Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 12-23-04 Kalas Crematory Edgewater, MD 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Mount Mu 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** uel 90 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ triue 1 Yes 2 No 3 Probably Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 □ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA this the funeral Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Natural 2 Accident Injury 5 Pending death. 1 Yes 2 No investigation efter death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled i within 24 hours e To the Funerel I 29a. Certifier Celtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 (Check only one) dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) erson who completed cause of death (Item 23a) (Type, Print) Chopra, M.D. 600 Ridgely Ave Suite 231 Annapolis, MD. 21401 Aditya

State
Registrar

31. Date filed (Month, Day, Year)

DEC 28 2004

		•	1 - For State Ragistrar	State of	Marylan		artment rtificate					Reg. No.	04	4277	8
}	Physici /Medio Examin	al	Decedent's Name (First, Middle Patricia Lewis A. Facility Name (If not institution 237 Anchorage)	Rementer Sa			4b. City, To				2. Date of De Month Decembe	Day		3. Time of Death 1:00 PM	
	Funeral Director		5. Social Security Number 206-14-7076 Usual Residence of Decedent	6. Sex 7. 1 ☐ M 2 € F	Age (In yrs.	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da	th y, Year) 2, 1926	9. Birthpl Count Penn	ace (State or Foreigr try) sylvania	7
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show fra Madical Examirer man be notified at	Director	10a. State 10b. County	Arundel		y, Town or Lo		ode				10g. Citizen of V		Od. Inside City Limits 1 ☐ Yes 2 ☐ No	
	death with	Funeral DI	237 Anchorage	12. Was Decede		ver in U.S. 13. Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ric						United States Yes or No- 14. Race - American Indian,			
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Maryland	iould be file I Mental Hyg wrkad othe	To Be C	17. Father's Name (First, Middle, George B. Remen	nter					Berth	a Au	igusta	Middle, Maiden Sumame) ta Briggs Number, City or Town, State, Zip Code)			
re, Mar	ore, wally ice		19a. Informant's Name/Relations Emil Saroch/ hus 20a. Method of Disposition	band	20b. F		anchora	ag e	Court	Ann		MD 21	401		
Baltimore,	permit. Pages Department of Important: If it sny injury or o		1 Burial 2 Cremation 4 Donation 5 Other (S 21. Signature of Funeral Service	Specify)	310	ingtor	Natio	onal Address	Cem of Facility	Joh	n M. T		unera	, VA 1 Home, In MD 21401	nc
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	To the Hospital or A within 24 hours after To the Funerel Direct completely filled in by	edical (29a. Certifier 1 Certifyii (Check only one)	ng Physician: To the b Examiner: On the bas and manne	is of examina	owledge, deat ation and/or in	h occurred at vestigation, in	the time	, date and nion, death	place, a occurre	nd due to the	cause(s) and ma	inner as sta and due to	ited. the cause(s)	
)	Withi To t	2	29b. Signature and title of certifie	extrem)	Har	un)		License		8		Dec ,			
			30. Name and address of person A. Stephen	HANSMA	of death (Item	n 23a) (Type,	Print)	ter	Rd	# 30-	3, ANA	VApolis	M	2004	1
	Sta Registi		31. Date filed (Month, Day, Year)	2 8 2004 2	strar's Signa	ature	book	1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** Month Year 12:30 P M Jack 25. Turner December 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 30532 Creekview Drive Princess Anne If Under 1 Year If Under 24 Hrs. Somerset If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Hours Director 424-24-2476 78 01/21/1926 Alabama Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f show the Modical Examiner must be notified at 1 Yes 2 No Directo MD Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30532 Creekview Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Neyer Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Master Chief Radioman U.S. Navy 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental ပ Charles Turner Mazie Ward permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 is mar any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 340 Timber Blvd., Lebanon, PA Connie Wensell/Daughter 17042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory | 12/28/2004 | Salisbury, MD 21. Signature of Funeral Service Licensee Hinman Funeral Home 11673 Somerset Ave., Princess Anne, MD 21853 once. 211 ∕M00295 29. and 1. Enter the disease, or complications that which the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on with line. Approximate Interval Betw In mediate Cause (Final disease or condition resulting in death) ASCVD **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to has a consequence of): Examiner The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760. Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) the 9 TUnknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 99 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? Yes 2 2 No certificate 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles D Steaman MD. 30434 MtVernonRd, Princess Anne, MD 2185 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 2 9 2004

	Physici		1 - State Registrar 1. Decedent's Name (First, Middle, Las	,	Cei	rtificate of l	Death	2. Date of Death Month	Day Year	3 Time of Disath			
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920	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinating the notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes ZY No If Yes, Give Year or Dates:	1	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Yes 2 No Specify:			United State T No- 14. Race - American Indian, Black, WMMF Fican Specify: America				
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			Registrar 1. Decedent's Name (First, Middle, Last)		001	uncate of i	Jealii	2. Date of De	ath	3. Time of Death
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ь	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. 81	Yrs.	Months Days	Hours Min	. (Month, Da		thplace (State or Foreign
	D		Usual Residence of Decedent					May 5,	1923 NOI	th Carolina
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36	within 72 hours after death with the Maryland ene. than "netural", or iteme 23e or 28e-f ehow te Mudical Exercities mast be routified at	y Fu	1 ☐ Never Married 2 🔀 Married	1 ☐ Yes 2 ☐ No 195	* 1	Tes, specify Cuba	Specify:	nto rican, etc.)	Black, Whit	o,oc. √hite
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0	(3)		30. Name and address of person who com			Print)				
			P. Gregory Rausch	MD 501 Wes		nth St.,	Frederi	ck, MD	21701	
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State of Maryland / Department of Health and Mental Hygiene O O I

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1		State Registra
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1-	For State Registrar
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For State Registrar	Certificate of Death	Reg. No.	4218
. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
LYDELL DANNY TAYLOR		DECEMBER 24 200	11.00

Physician	
/Medical	
Examiner:	

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23s or 28e-f show any injury or other traumatic event, I're Medical Ever and extransit be rediffed at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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		(First, Midd		YLOR								2. Date of Month DECH		R 24	Year 20		Time of Death
4a. Facilit	ty Name (If	not institutio	on, give stre	et and nur	mber)			4b. City,	Town, or	Location	of Death			4c. County	of Deat		
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	Security Nu		6. Sex			In yrs. last		If Under			r 24 Hrs.	8. Date of		MONI			
			1 🔯 M	2 🗆 F		•	Yrs.	Months	Days	Hours	Min.	(Month,	Day, Ye	_			(State or Fore
	-66-92 sidence of I		1		25							11.	18 7	9	New	Yor	'K
10a. State		10b. County	ν		10	0c. City. T	own or Lo	cation								10d I	nside City Limi
MD		Princ	e Geo	rges		-	on Hi										Yes 2□1
MD 10e. Stree 1113 11. Marita 1 N 3 W	et and Num	ber					-	10f. Zip	Code				10g.	Citizen of	What Co	untry?	
1113	Marc	y Ave	nue					2	2074	5			_	U	SA		
11. Marita	al Status		12.	Was Dece Armed Fo	edent Eve	er in U.S.	13.	Was Deced	dent of Hi	spanic O	rigin? (Sp	ecify Yes or Rican, etc.)	No-		e - Ame		ndian,
1 □ N	lever Marrie	d 2⊡xMar	rried	1 ☐ Yes If Yes, Giv	2₽No			_									
` 3 □ W	Widowed 4	Divorced	d	Year or Da	ates:			1 🗆 Yes	ZXI NO	Specify				Specif	ecity: Black		
		15. Deceder				1	6a. Deced	dent's Usua	al Occupa	ation			16b	. Kind of B	usiness/l	Industr	v
		y only highe			4		(Give life. l	kind of wo	rk done d se retired	<i>turi</i> n <i>g m</i> o)	st of work	ing					•
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19a. Info	rmant's Nar	ne/Relations	ship <i>(Type,</i>	Print)		- 11	19b. Mailin	g Address	(Street a	ind Numb	er or Rur	al Route Nu	mber, Cit	y or Town,	State, Z	ip Cod	le)
Kiya	na Ta	ylor/	Wife			1	5608	Livir	igsto	on Te	rr.	#101 ()xon	Hill	, MD	. 2	0745
	hod of Dispo	· · · · ·						-				Date	-				
1 🖾 €	a. Method of Disposition 1 \omega Burial 2 \subseteq Cremation 3 \subseteq Removal from State 1 \omega Disposition (Name of cemetery, crematory or other place) 1 \omega Disposition (Name of cemetery) 12-30-04 Washingtor										•						
21. Signa	ature of Fun	eral Service	Licensee				22	. Name an	d Addres	s of Facil	ity MΔ	rshall	re F	uners	1 H	λm _Φ	
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220 Bod	To all	1) 44	MILL		augad the	a donth - F						or respirator		п, р.	U• 2		roximate
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if arry, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												N F 5					
					1211											_	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown									23d. Date of delivery Month Day Year								
Part II Oti	her signific	ant conditi	ions contrib	uting to de	ath hut n	ot regultin	o in the un	dorhina	uca awa	a in Dart		23a D	d tabasa	o uco conti	ributo to	the sec	use of death?
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15V0	xxx	VUV	フレン	VLO	>+	our	SIA	><]] 1	⊒ Yes	24Z] No	3 ☐ Pro	bably	4 Unknow
ļ						-						24a. W	as an topsy rformed?	24b. V	Vere autorior to or	opsy fi	ndings availab ion of cause of
												1 Ye			Yes	2 🗆 1	No
25. Was o		d to medica								26. Place	of Deatl	h (Check on	y one)				
1 🗆 Y	_/	0	Hosp	oital:	npatient	2 🗆 ER/	Outpatient	3 □ DO	A Othe	r. 4□N	ırsina Ho	me 5 Re	sidence	6 🗆 Oth	er (Speci	ifv)	
27. Manns	or of Death		2	8a, Date o	of Injury	281	b. Time of		Bc. Injury Work			28d. Describ				-9/	
14ZN		5 Pendir	ng igation	(Monti	h, Day Ye	ear)	Injury	М		? ′es 2. [_							
1								er or Rur	al Rou	te Number,							
	GCK OTHY 2	Certifyin	ng Physicie Examiner:	On the ba	ISIS OF OX	amination	dge, death and/or inv	occurred a	at the time	e, date ar inion, dea	nd place,	and due to the	ne cause e, date a	(s) and ma	nner as s	stated.	ause(s)
	''			and mann	er stated												
29b. Sign	na/ultel and ti	tle of certifie	n	The	6			290	D61	number 892			29d. E	Date signed	(Month.	Day,	Year)
4	Homicide tifier 1 pock only 2 na(u) and ti	Certifyin Medical	ng Physicie I Examiner:	en: To the On the ba and mann	best of masis of exider stated	ny knowled amination	dge, death and/or inv	occurred a estigation,	at the timin my op License D61	number 892	nd place, ith occurr	City or	ne cause e, date a	(s) and maind place, a	nner as sand due to	Day,	eause(s) Year)

State Registrar 31. Date filed (Month, Day, Year) DEC 3 0 2004

10 CENTER DRIVE, BETHESDA, MARYLAND 20892 32. Registrar's Signature

			1 - For State Registrar	State of Marylan		artment of h		Reg	g. No) 1	14 4.2	700	
I	Physici /Medic		1. Decedent's Name (First, Middle, Last) Mieczyslaw Jose	ph Tupaj				2. Date of Death Month December		Year 004 5:05	of Death U	
	Examir	ner	4a. Facility Name (If not institution, give some Crofton Convelesc	·		4b. City, Town, o	or Location of Death on		4c. County o	f Death Arunde1		
	Funeral Director		5. Social Security Number 6. Sex 032-16-5510	7. Age (In yrs.) M 2 F	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 09/06/19	(ear) 927 1	9. Birthplace (State Country) Massachus		
Maryland Z1Z15-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel', or items 23e or 28a-f show prighty or other treumatic event. The Medical Exam and must be inclined at ance.	To Be Completed by Funeral Director	Maryland Anne Arun 109. Street and Number 13901 Old Stage Ro	ad 12. Was Decedent Ever in U. Armed Forces? 1X_IYes 2 No If Yes, Give Year or Dates: 145-1. cation a completed) College (1-4or 5+)	16a. Deced (Give life. I	10f. Zip Code 20720 Was Decedent of Information of Yes, specify Cubin of Yes, specify Cubin of Yes 2√√2 No Hent's Usual Occupation of Work done OO NOT use retired ter	dispanic Origin? (S; an, Mexican, Puerto Specify: Pation during most of work during the standard of the during the standard of	pecity Yes or No- pecity Yes or No- No- No- No- No- No- No- No- No- No-	Specify: White 16b. Kind of Business/Industry Federal Printing Office ddle, Maiden Sumame)			
Dalillinore, M	permit. Pages 1 and 28 bepartment of Health Important: If item 27 I eny injury or other tre		Kim Jane Tupaj / Daughter 129 Smith Avenue Annapolis, Maryland 21 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityRobert E. Evans Fune 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							le, Mary neral Home and 20715	e	
E	Physician and physician and physician and physician and the prinal-transit the prinal-transit the prinal-transit the physician and physician a	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dease or nur) that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	ence of):	NCER				Interval Ber Onset and	Death	
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	e attending I	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnar 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	,	Year	
	been signed be should be deta	by								tobacco use contribute to the cause of death? Yes 2 □ No 3 □ Probably 4 ★Unknown		
	ate h	e Completed	25. Was case referred to medical					24a. Was an autopsy performed	d? pric	re autopsy findings or to completion of c th? Yes 2 \(\text{No} \)	available cause of	
Or Attending Physician	After this	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?					th Check only one) ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
oite or Ar	eral eral		3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)				28f. Location (Stree City or Town, S	State)		nber,	
To the Upper	within 24 hours are to the Funeral completely filled	fedical	one)	ician: To the best of my know er: On the basis of examinati and manner stated.	rledge, death on and/or inv	estigation, in my op	pinion, death occurr	and due to the caus ed at the time, date	e(s) and mann and place, and	er as stated. I due to the cause(s	3)	
F	with	Σ	29b. Signayus and title of certifier 30. Name and address o person who cor	llan un	9	29c. License				Month, Day, Year) R 28, 21	pog	
	Star Registra			JZ. gistiai s Signati	23a) (1ype, F	KILB.	RIDE R	De D, BALTI	MOREI	40 212	36	

			For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of F			iene .g. N2 0 0 4	1.2701	
	Physici		Decedent's Name (First, Middle ATHY	e, Last)	VORTER			2. Date of Deat Month	h Day Yeer	3. Time of Death	
	/Medic Examir		4a. Facility Name (If not institution Shady Grove Adv	_	er)	7	r Location of Death		4c. County of Death Montgomery		
	Funeral Director		5. Social Security Number 579.68.5454 Usual Residence of Decedent		Age (In yrs. last birthday, 63 Yrs.			8. Date of Birth (Month, Day, April 2		nplace (State or Foreign	
	e Maryland a-f ahow lifted at	ctor	10a. State 10b. County	gomery	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
	th with the 23a or 28	al Director	10e. Street and Number 14505 Briarwood			10f. Zip Code 20853			0g. Citizen of What Col	untry?	
036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f ahow event, the Medical Exam avent.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marriad 3 □ Widowed 4 □ Divorced	If Yes Give	s? XINo	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2K No			14. Race - Amer Black, White Specify:		
21215-0036	within 72 ho ene. than "natur he Medicel	Completed	(Specify only higher	t's Education st grade completed) College (1-4c	or 5+) (Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of world	king	16b. Kind of Business/l	ndustry	
Þ	2 should be filed within and Mental Hygiene. Ia marked other than raumatic event, the Me	To Be Co	12th 17. Father's Name (First, Middle, Pakyim Cheng	Last)	Flori	Lst	18. Mother's Nam	e (First, Middle, M		igns/ Retail	
e, Mary	f and 2 sho fealth and P m 27 ia ma fer trauma		19a. Informant's Name/Relations Kiat Voritskul		14505	Briarwoo	od Terrac	e, Rockv	City or Town, State, Zi ille, Mary	land 20853	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If them 27 is marked any injury or other traumatic angree.		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S 21. Signature of Funeral Service	pecify)	Gate of H	matory or other plac Ieaven Cer	^{⊕)} net. 12/3	1/2004 S	20c. Location - City or T ilver Spri LDI FUNERA	own,State ng, Marylan L HOME, INC	
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that caus only one cause on each						Approximate Interval Between Onset and Death	
ŀ,	Medical by Sician and Sirie private the private transit stree burial transit street s	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (cr :	as a consequence of): as a consequence of): as a consequence of):						
. Box 6	death certiff e attending d for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year	
rds, P	signe d be c	by	Part II. Other significant condition	ons contributing to death	but not resulting in the u	nderlying cause give	on in Part I.	23e. Did toba	acco use contribute to t		
		Completed						24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of	
Division of Vital	ding Phys h. After this funeral dii	ation; To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pendin investig	Hospital: Inpa 28a. Date of In (Month, D	ijury 28b. Time of	me 5 Residen 28d. Describe how	ence 6 Other (Specify)				
DIVIS	spital or Atten ours after deatl neral Director: filled in by the	Certification;	3 Suicide 6 Could r 4 Homicide determ	ined 286. Place of I building,	nju ry - At home, farm, str etc. <i>(Specify)</i>	,		City or Town,	Location (Street and Number or Rural Route Number, City or Town, State)		
	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by	Medical	29a. Certifier (Check only one) Certifier (Check only one) Medical I	and manner	st of my knowledge, death of examination and/or inv stated.	restigation, in my op	inion, death occurr	ed at the time, dat	e and place, and due to	o the cause(s)	
	25		30. Name and address of person of	i. \$200	Pu Min	29c. License	7-285	De 290	d. Date signed (Month,	5 2004	
	Sta		James A. Brown	M.D., 9707	Medical Cer	,		Rockv111	e, MD 20850)	
	Registra	ar	DEC 29	ZUU4	No.	jupours					

			1- State of Maryland / Depart Registrer 23a per Dr., G839, 01/11	tment of Health and N 3/05dhb ilicate of Death	Mental Hygie	ne2004 42785							
	Physici	an	1. Decedent's Name (First, Middle, Last) Ercelene S Wilkins		2. Date of Death Month	Day Year 3. Time of Death							
	/Medi Examir			4b. City, Town, or Location of Death		2004 4:30 A M							
1	Lydilli	1ÇI	5509 Keppler Road	Temple Hills		Prince George's							
	. Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 273 24 4373 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Oct 31, 19	9. Birthplace (State or Foreign Country) 917 Ohio							
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation		10d. Inside City Limits							
	Marylan -1 show lied al	tor	Maryland Prince George's Temple	Hills		1 ☐ Yes 2 ThNo							
	th the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?							
	ath wi	rai	5509 Keppler Road	20748	Ţ	United States							
(0	be filed within 72 hours after death with the Maryland hat Hygiene ad other then "neture!", or Items 23c or 28e-1 show event. The Modified Examiner matter pulling at	Funeral	Armed Forces? If Y	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puert <i>o</i>	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.							
21215-0036	nours a	by	XX Widowed 4 □ Divorced If Yes, Give Year or Dates:	☐ Yes 2√TNo Specify:		Specify: Black							
15-(in 72 l	Completed	(Specify only highest grade completed) (Give killing DC	nt's Usual Occupation nd of work done during most of work O NOT use retired)	ding 16b	b. Kind of Business/Industry							
212	od with giene. er ther	Som	Elementary/Secondary (0-12) College (1-4or 5+)	Estate Agent		Ridgeway							
Maryland	12 should be filled within h and Mental Hygiene. 7 Is marked other then " treumetic event, the M.	To Be (17. Father's Name (First, Middle, Last) Staton Snell		e (First, Middle, Maid a Cowans	den Sumame)							
, Mar	s 1 and 2 should f Health and Men item 27 Is marke other treumetic		19a. Informant's Name/Relationship (Type, Print) Yvonne A. Wilkins (Daughter) 19b. Mailing 5509	Address (Street and Number or Run Keppler Road, Tel	mple Hills	ity or Town, State, Zip Code) s, MD 20748							
Baltimore,	0 0		Appunal 2 Cremation 3 Hemoval from State	tion (Name of tory or other place) Cemetery Dec 29,		c. Location - City or Town, State Oxford, Ohio							
Balti	permit. Pag Department Importent: I eny injury o once.		21. Signature of Funeral Service Licensee 22. 1	Name and Address of Facility Lee	Funeral H	Home, Inc, 6633 Old							
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.			Approximate Interval Between							
	Physician		Immediate Cause (Final disease or condition a. CARSIO-PULMOWARY ARREST										
	/Medical Examiner		Due to (or as a consequence of): Metastatic Cancer										
	• #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
	xecute and al-trans	Examiner	Cause (Disease or injury that initiated events c										
8760,	cate be executed bhysician and the burial-transit	dicai E	d.										
Box 6	leath certific attending p I for use as f	Φ	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery							
o.	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	ctopic pregnancy Other (specify)		Month Day Year							
ds, P	luires that n signed b	by	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did tobacc	2 No 3 Probably 4 Unknown							
Vital Records,	law requir as been s 2 should	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of							
a B					performed	? death?							
Vit		o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death 3 DOA Other: 4 Nursing Hor	h (Check only one)	a □0.1							
n of	ng Phys fter this ineral di	on: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how in								
Division	ol or Attending P after death. I Director: After t d in by the funera	icati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f Location (Street	and Number or Rural Route Number.							
Ω	s after s after ol Dire	Certification:	4 Homicide determined building, etc. (Specify)	t, lactory, office	City or Town, St	and Number of Hural Houle Number, ate)							
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death of the basis of examination and/or investigation and manner stated.	and due to the cause ed at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)								
	To t To tl	Ž	29b. Signature and title of certifier	29c. License number 50932		Date signed (Month, Day, Year)							
7	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri		_ /	2/23/04							
			Vilma Mascarenhas, M.D., 6502 Kenilwo		verdale, N	MD 20737							
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 3 2005 32. Registrar's Signature	P									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per or , G843, 05/19, 05/ahb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** 1644 PM R December 23 2004 /Medical 4a. Facility Name (If not institution, give street and number, 4b. Gity, Town, or Location of 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1 M 2 □ F 213-98-2136 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or Itams 23a or 28a-f show any injury or other traumatic avant, II a Madical Examinat must be rollified at once. DOMERSET PRINCESS H 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21853 USA DADFuneral 12. Was Decedent Ever in U.S. Armed Forces? 1 \$\forces\$ Yes 2 □ No. 147 ês, Give Year or Dates: \(\rightarrow 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DNSTRUCTIONLO 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be VIRGINIANI. HARL STURGIS 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) 19a, 29501 SCAND RD TRIM SHAWE ND 2153 MOTHER - NEHL IRGINIA WI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 🗆 Burial Cremation 3 Removal from State DOVER 3/05 APITOL 5 ☐ Other (Specify) * 4 □ Donation REMATORI 22. Name and Address of Facility SMITH 21. Signature of Fun al Service Licensee BEWDIE SALISBURY ST ND Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Kespiratory Syndrome days /Medical Due to (or as a consequence of): **Examiner** neumonia week if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ng physician and as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Q 2. No 3 Probably 4 Unknown transplant 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an mmune To the HoapItal or Attanding Phyaician: The lav within 24 hours atter death. To the Funeral Director: Atter this certificate has autopsy performed' 1 ☐ Yes 2 🗆 No 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) KES 000 December 30. Name and address of person who completed cause o ath (Item 23a) (Type, Print) Johns Hopkins Hospital Bultimore Md 21287 600 N. Wolfe Massaretti 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 28 2004 Registrar

Carlton Woodhowar SS#045-27-3744

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P.O.	
Records,	
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			For State Registrar	Otate of Mary		rtificate of			2004	42787
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	or 28e	Director	10e. Street and Number		aples	10f. Zip Code		100	g. Citizen of What Co	untry?
	ath wi		112 Bristol Lane			34112-			USA	
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036	72 hours after death with the Maryland neture!', or Items 23e or 28e-1 show Jissi Evar in et must be rodified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: KOI	-	1 ☐ Yes 2X No	Specify:		Specify:	hite
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d 2	filed I Hygid other	Be Co	17. Father's Name (First, Middle, Last)	<u></u>	COM	deer And	7	ne (First, Middle, Ma		3
ylar	should be ind Mental marked c	To E	Fred	Wood	house		Ida		Bronke	
Maryland	2 sh and and ls m		19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Stree	t and Number or Ru	ral Route Number, (City or Town, State, Zi	ip Code)
	s 1 and soft Health item 27 other tr		June M. Woodhouse 20a. Method of Disposition	(wife)	 Place of Dispo 	sition (Name of		es, Flori	da 34112- c. Location - City or T	-5420 Fown, State
D E	Pages trent of to ont: If its lury or of		1 ☐ Burial 2 【XCremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)			matory or other pla	' I	or 27 201 V	Sala churu	, Maryland
Baltimore,	permit. Deparrimpone any i ju	-	Signature of Funeral Service License	90	2:	Name and Addr	ess of Facility			
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R			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	A Do not en	er the mode of dy	ing, such as cardiad	or respiratory arres	Later to the second	Interval Between Onset and Death
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	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a cons	sequence of):		1			
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	as this	by P	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause gr	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
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n of	Attending Physicien: r death. ector: After this certific by the funeral director.		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year	28b. Time o Injury	f 28c. Inju Wo		28d. Describe how		
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	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier (Check only 2 Medical Examir	sician: To the best of my liner: On the basis of exam	knowledge, deat	n occurred at the t	ime, date and place,	and due to the caus	se(s) and manner as	stated.
	thin 24	Medical	one) 29b. Signature and title of certifier	and manner stated.	matter and of m		se number		. Date signed (Month,	
}	10 40		1	me D.	J.		58487	290	7-127-101	
	CINT		30. Name and address of person who co	mpleted cause of death (I	tem 23a) (Type,	Print)			-10-10-	1
	IVM		HONARD GILME	K, D.O.		DRROIL	51. 3.	ALISBUM	Mo	
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			1 - State Registrar			d / Depa		lealth and	Mental Hyg		
			Decedent's Name (First, Middle, Last)				Timodito or		2. Date of Deat	eg. No.	3. Time of Death
	Physici		Eriszenia Fay				Month Dec.	25, 2004 3 30A			
	/Medic Examir		4a. Facility Name (If not institution, give s				4b. City, Town, o	r Location of Deat		4c. County of De	
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	Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	9. 6	Birthplace (State or Foreign
	Director		220-28-4841	M 201 85	i	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month Day,	919	Birthplace (State or Foreign Country)
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	vith th	5	10e. Street and Number	_			10f. Zip Code		1	0g. Citizen of What	Country?
	filed within 72 hours after death with the Maryland Hygiene. Ather than "natural", or Items 23a or 28e-f ahow ant, the Medical Examinar must be notified at	Funeral Director	32641 Johnson Road				21804			USA	
	er.de Item	E E		12. Was Decedent Armed Forces?		S. 13. \	Was Decedent of H f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Hace - As Black, W	mericen Indian, hite, etc.
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<u>a</u>	uld b Ment Ment rked rific e	70	Adolphus Columbus	Sines				Sarah Ma	artha Sah	royer Sin	es
lan	2 should be and Mental is marked or reumatic ever		19a. Informant's Name/Relationship (Typ			19b. Mailin	g Address (Street	and Number or Ru	ıral Route Number,	City or Town, State	, Zip Code)
Σ,	and and n 27		Jean Miller, Daug	nter					Salisbury	, Md. 218	04
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should by Oppurment of Health and Menia Important: If item 27 is marked any njury or other treumatic and ODEs.	10	20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Re	amoval from State			sition (Name of natory or other plac			20c. Location - City	or Town, State
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	sit sit	Examiner	Securatially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that half because the cause of the cause	Due to (or a	a con - u	ence of):					•
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Division of	l or Attending after death. Director: After I in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ury - At hor	me, farm, stre	et, factory, office		28f. Location (Str	eet and Number or I	Rural Route Number,
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	ospil hour unera ly fille		29a. Certifier 12 Certifying Phys	ician: To the best of	of my know	vledge, death	occurred at the tin	ne, date and place	, and due to the ca	use(s) and manner	as stated.
	To the Hospital or Attending Physicien: The law requires that the death certifical within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only 2 Medical Examin	and manner sta	examinati ited.	on and/or inv	restigation, in my o	pinion, death occu	rred at the time, da	te and place, and de	ue to the cause(s)
	To t	Σ	29b. Signature and title of certifier				29c. Licensi	number	29	d. Date signed (Mor	nth, Day, Year)
			1-0/-/	W			Da	4486		12/28/	04
1	in		30. Name and address of person who cor	npleted cause of de	eath (Item	23a) (Type, I	Print)	(827)	6	W.	
	771		Robert J. Reilly 1	0 56	ORig	rereid	- O- OI	of Salie	100g 100	1. 2180	f
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McKinley Walker 219-63-7418

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	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tox	vn or Location		10d. Inside City Limits
	a-f sh	ctor	MD WICO	mico F	BUITLAND		1⊠Yes 2 □ No
	or 28	Director	10e. Street and Number		10f. Zip Code		g. Citizen of What Country?
	eath v is 23e		11. Marital Status	R STREE!	2/82		USH
9	after d or Itan niner	Funeral	1' Never Married 2 Married	Armed Forces? 1 □ Yas 2 □ No If Yes, Give	13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi		14. Race - American Indian, Black, White, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show he Ma-fical Evantiner must be invitted at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Spec	ify:	Specify: BLACK
15-	in 72 t	Completed	15. Decedent's E (Specify only highest gra	ade completed)	 Decedent's Usual Occupation (Give kind of work done during n life. DO NOT use retired) 	nost of working	Sb. Kind of Business/Industry SUPER (LI=A)
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	be filed ital Hygi id othar avant, I	Be	17. Father's Name (First, Middle, Last,	1 . \		other's Name (First, Middle, Ma	uiden Sumame)
Maryland	hould be d Mental markad matic av	ဥ	17/ RINLEY +	1. WALKER	DK DE	LOIS M. LAU	US KDUSE
Ma	Ith an 27 is r		19a. nformant's Name/Relati inship (SISTER 1	b. Mailing Address (Street and Nur	St D V \in R	City or Town, State, Zip Code)
Jre,	es 1 au of Hea fitam rotha		20a. Method of Disposition	20b. Place	of Disposition (Name of ary, crematory or other place)		c. Location - City or Town, State
Baltimore,	Pages ment of ant: If it	١,	1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Hemoval from State / }	TOL CREMATORY	113/05	DOVER DE
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If itam 27 is markad othar than "natural", or Itams 23a or 28a-1 show any injury or othar traumatic avant, the Medical Examinat must be nothined at once.	1	21. Signature of uneral Service Licer	isee []	22. Name and Address of Fa	cility BENNIE	
			23a. Part1. Enter the disease, or com	plications that caused the death. Do	not enter the mode of dving, such	ABELLA ST	SALISBURY MD 21801
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Вох	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
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Division of Vital	ng Ph kiter th uneral		27. Manner of Death 1 ☑Natural 5 ☐ Pending		Time of 28c. Injury at linjury Work?	28d. Describe how	injury occurred
isio	ttandi death. tor: A	icatl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 ☐ Yes 2		
<u>S</u>	al or A after 1 Dirac d in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	City or Town, S	et and Number or Rural Route Number, State)
	hours unara unara		29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exan	ysician: To the best of my knowledg	e, death occurred at the time, date	and place, and due to the caus	se(s) and manner as stated.
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	0110)	niner: On the basis of examination are and manner stated.			
	To wit	-	29b. Signature and title of certifier	1000	29c. License numbe	290	Date signed (Month, Day, Year)
,	100		30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print)	4-1	12/00/01
	10		Alon Davis me	100 Power	Ct Sclichury	MD 2180	4
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 8 2004	32. Registrar's Signature	Sparks		
	negistr	41		/ /	_//		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	e of Maryland /	Departm Certific	ent of Heacate of De	alth and Me eath	ntal Hygier		42790
	Physic	ian	Decedent's Name (First, Middle, Last)				2.	Date of Death	Day Year	3. Time of Death
	/Med Exami	ical	ROBERT LEE WOOD 4a. Facility Name (If not institution, give street as	nd number)	4b.	City, Town, or Loc		ecembe	4c. County of Death	11609
	LAGIIII		The Momorial	Hosp, tal		Eas	ton		Talk	of
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last t	birthday) If U Yrs. Mor		Under 24 Hrs. 8. lours Min.	Date of Birth (Month, Day, Yea NUARY 6	9. Birth	pplace (State or Foreign Intry) RYLAND
	Director		212-38-6719 XX Y Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z				D E	MUARI O	1933 FIX	KILAND
	arylan show	_	10a. State 10b. County	0.77	wn or Location					10d. Inside City Limits
	the M	Director	MD QUEEN ANNE 1	s Qu	JEEN AN	NE f. Zip Code		100	Citizen of What Cou	1 ☐ Yes ¾XXNo
	h with	io le	31763 OLD QUEEN ANNE	RD.		216	57	109.	USA	311117
	r deat	Funeral	11. Marital Status 12. Was	Decedent Ever in U.S. ed Forces?	13. Was D	ecedent of Hispa specify Cuban, N	nic Origin? (Specif Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Amer Black, White	
7	36 rs afte	by Fu	If Ye	Yes 2 ☐ No es. Give r or Dates:		es 2 No S			Specify: WHI	
000	5-00	ted	15. Decedent's Education (Specify only highest grade compl	16		Usual Occupation	n ng most of working	16b.	. Kind of Business/li	
2	Mithin han "	Completed	Elementary/Secondary (0-12) Coll	ege (1-4or 5+)	life. DO NO	OT use retired)	ig most of working		A CD T CITI TO	пре
7	d 2 filed v Hygie othert		12 0 17. Father's Name (First, Middle, Last)		FARM		. Mother's Name (F	irst, Middle, Maid	AGRICULT	UKE
+	Maryland 21215-0036 of 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. 27 Is marked other than "naturel", or Items 23a or 28a-f show traumatic event, the Medical Engin and the rotified at	To Be	JOHN LAWRENCE WOOD,	SR			MARY KI	TTO		
bert	Alary 2 sho 2 sho 1 and 1 1s me		19a. Informant's Name/Relationship (Type, Prin	100	-				y or Town, State, Zi	
	e, N 1 and Health em 27 ither tr		SCOTT WOOD/SON 20a. Method of Disposition	20b, Place	of Disposition	(Name of	ANNE RD		ANNE, MD	
The same of the sa	Pages nent of l		1 Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State cemet	tery, crematory	or other place)	RY 12-27-		ORDOVA, M	
	Baltimore, M. permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Licensee	-					M FUNERAL	
	0 88558			ERLERO	200	S. HARR	ISON ST I	EASTON, 1	4D 21601	
	ug.		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final	on each line.				spiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical	ı	disease or condition	SMAW BO		SCHEMI	A			
	Examiner			ACUTE RE	ENAL	FAILU	RE			
	ed sit	Jiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a consequence		W				
	'60, be executed sician and burial-transit	Examiner	that initiated events	ue to (or as a consequence	-	"/-				
	8760, cate be ext chysician a the burial.	dical								Ü
	x 68 ertifica ding ph	Med	IF FEMALE:							
	Box 6	by Physician/Me	in the past 12 months?	s, outcome of pregnancy Live birth 2 ☐ Fetal dea Pregnant at time of death		r (specify)			23d. Date of deliv Month	rery Day Year
	P.O.	hysi		Unknown	0.000	· (opee//)/				
	S, F		Part II. Other significant conditions contributing	to death but not resulting	in the underly	ing cause given in	Part I.		o use contribute to t	
	Division of Vital Records, to a teach and teach at a teach and the star death. Director: After this certificate has been signed in by the funeral director, page 2 should be or the star and the control of the star and the star	Completed						1 Tes		
	The law cate has I page 2 s	Jumo						24a. Was an autopsy performed?	24b. Were auto prior to co death?	opsy findings available ompletion of cause of
	Vital F sician: Th certificate irector, pag	Be Co	25. Was case referred to medical			26	. Place of Death (C	1 ☐ Yes 2 ☑	No 1 ☐ Yes	2[P No
	of V Physic this ce al direc	2	examiner? 1 Yes 2 No Hospital:	1 Inpatient 2 ☐ ER/C			¹ ☐ Nursing Home	5 Residence	6 ☐Other (Specia	fy)
	On Ol Ol Ol Ol Ol Ol Ol Ol Ol Ol Ol Ol Ol	tlon:		Date of Injury (Month, Day Year)	Time of Injury M	28c. Injury at Work?	28d	. Describe how in	jury occurred	5.
	Division of after death. I Director: After the full of	Certification:	3 Suicide 6 Could not be	Place of Injury - At home,				Location (Street	and Number or Run	al Route Number,
П	itet or ris afte rel Dir	Cert		building, etc. (Specify)				City or Town, Sta		
	Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician: 1 2 Medical Examiner: On and	To the best of my knowledge the basis of examination a manner stated.	ge, death occu and/or investiga	rred at the time, o ation, in my opinio	late and place, and n, death occurred a	due to the cause at the time, date a	(s) and manner as s ind place, and due t	stated. to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier			29c. License nu	mber	29d. D	Date signed (Month,	Day, Year)
			> folial setus	7		D005	7487	iá	2/20/04	
			30. Name and address of person who completed JOHN BOTSIS D.O. 219			EASTON .	MD 21601			
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature		#	21001			
	Regist		DEC 2 3 200	14 Deserver	150	cold				

Please Type or Print in Black Indelible Ink. Ensure All Cop	ies Are Legible.
State of Maryland / Department of Health and Mental	Hygiene
Certificate of Death	0001

			For State Registrar	State of M		artment of H		Mental Hygiene	1001	1.2701
			Decedent's Name (First, Midd	le, Last)		711110010 07 2		2. Date of Death		3. Time of Death
	Physici		James	Edward		Windsor		Month Da		1427 M
	/Medi Examir		4a. Facility Name (If not institution)	4b. City, Town, or	Location of Death		. County of Death	1/2/
			Peninsula Regio	NOI Medical	Certer	540	13641		Hicomic	0
	Funeral		5. Social Security Number		ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthp	lace (State or Foreign
п	Director		219-46-4666	1 M 2□F	58 Yrs.	World S Day's	Modis Will.	01-21-1946		
	and **		Usual Residence of Decedent 10a. State 10b. Count	J	10c. City, Town or Le	ocation			1	Od. Inside City Limits
	Aaryli sho	៦	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	, ros only, rount of Es	5541571			1	1KYes 2 □ No
	28a-1	Director	MD Wico	mico	Salisbury	10f, Zip Code		100 0	izen of What Coun	
	with be or			W:11 D 1				Tog. Cil		uy:
	ne 23	era	4526 Coulbour 11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi		pecify Yes or No-	USA 14. Race - Americ	an Indian.
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. od other then "naturel", or Iteme 23a or 28a-1 show event. The Medical Examinar must be notified at	by Funeral	1 Never Married 256Ma 3 Widowed 4 Divorce	Armed Forces rried 1 Yes 2 1	No	Was Decedent of Hill If Yes, specify Cubar	Specify:	Rican, etc.)	Black, White, a	etc.
ò	2 hou	ted	15. Decede	nt's Education		dent's Usual Occupa		16b. K	Whi ind of Business/Ind	
215	hin 7.	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4or	life	kind of work done d DO NOT use retired)	luring most of world		erset Cou	ntv
21	d wit	mo	12	none	·	nistrator			ning & Z	•
bu	be filed tal Hygid d other event, t	Be	17. Father's Name (First, Middle	, Last)			18. Mother's Nam	ne (First, Middle, Maiden		
Ja	should be filed ind Mental Hygi i marked other umatic event, I	0	Guy Windsor				Mary Cov	ington		
Maryland	E E E		19a. Informant's Name/Relation			-		ral Route Number, City o		*
	1 and 2 Health tem 27		Linda Brown Wi	ndsor/Wife		4	ie Mill F	Road, Salish	oury, MD	21804
3altimore,	permit. Pages 1 and 2 s Department of Health ar Importent: If Item 27 Is any injury or other trau 20059.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from State	20b. Place of Dispo cemetery, crea	osition (Name of matory or other place	9)	Date 20c. Lo	ocation - City or To	wn, State
Ë	Pag ment ent: ury c		4 □Donation 5 □ Other (Specify)	St. Andre	ews Episco	pal 12-3	31-2004 Prin	icess Ann	e, Maryland
Sall	permit. Pages Department of It Importent: If Ite any injury or of		21. Signature of Funeral Service	111	H	2. Name and Addres inman Fune	s of Facility eral Home	2		1372
	207 e d	_	Anen /la	Men XI, 1	100295 1	1673 Somer	set Ave.	, Princess	Anne, MD	21853
		1	93 art1. Joier he isease, c shock, or hint failure. Lis	r complication that cause t only one cause on each l	d the death. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arrest,	1,50	Approximate Interval Between
	Physician	1	disease or condition	5	pris / 1	Ebrile	Ulnes	4		Onset and Death
	/Medical Examiner	-	resulting in death)	Due to (or as	a consequence of):					
	LAGITITICI	_	Sequentially list conditions,	b						
	sit ed	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequence of):					
_	sate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c	s a consequence of):					
8760,	be egician ician buria	<u>=</u>								
687		dicai		d						
	eath certifi attending I for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome	e of pregnancy				23d. Date of delive	n/
Вох	atter	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death 3	Ectopic pregnancy Other (specify)				Day Year
O.	that the dead by the detached	ıysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown						
Q	that the	Y P	Part II. Other significant condit	ions contributing to death	but not resulting in the u	inderlying cause give	n in Part I.	23e. Did tobacco u	use contribute to th	e cause of death?
ds.	uires t signe	d by						1 ☐ Yes 2	No 3 Prob	ably 4 Unknown
Records,	w require been sig should t	Completed						24a. Was an	24h Were autor	osy findings available
Re	The lavate has	m						autopsy performed?	prior to con death?	npletion of cause of
Vital		e Cc	25. Was case referred to medical	al			20 Pi(P	1 Yes 2 No	1 Tes	2 No
>	Physiclan: this certific al director,	o B	examiner?	Hospital: 1 ☐ Inpati	ient 2 ER/Outpatier	nt 3 DOA Othe	r	th (Check only one)	6 DOthor (Specific	al .
of			27. Manner of Death	28a. Date of Inj	ury 28b. Time o	f 28c. Injury	at	ome 5 Residence 28d. Describe how injur		7
Division	Attending In death. actor: After by the funer	tio	1 ☐ Matural 5 ☐ Pendi 2 ☐ Accident invest	ng (Month, Da igation	ay Year) Injury	Work	? ′es 2 □ No			
/isi	I or Attendi after death. Diractor: A I in by the fu	fica	3 ☐ Suicide 6 ☐ Could	mined 288. Place of In	jury - At home, farm, str	reet, factory, office		28f. Location (Street an		Route Number,
Ö	in Dir	Certification:	4 Homicide	building, e	tc."(Specify)			City or Town, State)	
	To the Hospitel or At within 24 hours after or To the Funerel Dirac completely filled in by	edical (29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physician: To the best I Examiner: On the basis of and manner s	of examination and/or in	h occurred at the time vestigation, in my op	e, date and place, inion, death occur	and due to the cause(s) red at the time, date and	and manner as sta I place, and due to	ated. the cause(s)
	To th within To th	Me	29b. Signature and title of certifi	er		29c. License	number	29d. Dat	te signed (Month, L	Day, Year)
	- > - 0		D H	0.30	Ma	1 2	2521	9 /	2/30/2	004
			30. Name and address of person	who completed cause of	death (Item 23a) (Type.	Print)	,		/-/	
			C. Stegman	(m.o.	30434 1	nt Verk	ION RO	Princess	Anne,	MO
	Sta	ite	31. Date filed (Month, Day, Year		rar's Signature					
	Registi	ar	JAN (3 2005	en !	Coarles				
DH	MH 17 Rev 1/2	001								

Mildred Williams 04-08247 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. crn State of Maryland / Department of Health and Mental Hygiene 3 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Mildred Ann Williams December 2004 1:46 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Doctors Community Hospital Lanham Prince George's Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 ☐ M 2 🔀 F 60 North Carolina 244-68-3257 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No MD Prince Georges New Carrollton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5927 85th. Avenue #102 20784 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if itam 27 is marked othar than Elementary/Secondary (0-12) College (1-4or 5+) Federal Reserve Board Food Service 12th. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary E. Williams Joseph Brown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dionne T. Williams/Son 5927 85th. Ave. #102 New Carrollton, Md. 20784 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: if any injury or once. Mt. Olivet Cemetery 12-30-04 Washington, D.C. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home Kall 4217 9th. St. N.W. Washington, D.C. 20011 Mais 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Henselentie Cardiovascular Disease **Physician** a. Hy porteusual AHP
Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy 1 Live birth 2 Fetal death jo in the past 12 months? 1.☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2□ No 10 Yes 2 □ No f or Attanding Physician: after death. Director: After this certification 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1X Yes 2 □ No Other 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2☐ER/Outpatient 3☐DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital

To the Hospital within 24 hours a To the Funaral D

R. 31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only one) 29b. Signature and title

Medical

30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) HOGAN

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Year

December 22, 2004

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

32 Registrar's Signature --

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. REPLACEMENT State of Maryland / Department of Health and Mental Hygienes Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Edward Eugene Whisman November 2004 1:35pm 29. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care - Chevy Chase Chevy Chase
If Under 1 Year | If Under 24 Hrs. Montgomeny

9. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) **X** M 2□ F Months Days Hours Min. 224-60-3301 Yrs Director 95 Aug. 2, 1909 Washington, D.C. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exeminer roust be notified at 1 ☐ Yes 2 ☐ No Directo Silver Spring | 10f. Zip Code Maryland | Montgomery 10e. Street and Number 10g. Citizen of What Country? 14400 Homecrest Road, Items 23a #18 20906 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Iten any injury or other traumatic event, the Medical Exprinter. once. Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Sumame) Edward Whisman Elizabeth Sarah Lockwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald E. Whisman/Son 4200 Dresden Street; Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metropolitan Crematory 12-1-2004 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one suse on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physiclan/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) P.0. ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page ŽŒ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 1 Yes 2 No Other: 4X Nursing Home 5 Residence 6 Other (Specify) Certification: To 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending after death. М investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

within 24 hours a To the Funeral C completely To the

> Sunitha Bhogavilli, M.D. 1220-A East Joppa Rd-Suite 230; Townson, MD 21286 31. Date filed (Month, Day, Year) 2005 Registrar

30. Name and address of Jerson who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29c. License number

D0054566

29d. Date signed (Month, Day, Year)

			- Table	State of Maryla				•	diene	
			1 - For State Registrar	•		rtificate of I			Reg. No. UU4	42794
	Physici	an.	1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month	ath Dey Year	3. Time of Death
	/Medic		Helen M. Witkiew			1 41. 7			er 25, 2004	5:00 PM
	Examin	er	4a. Facility Name (If not institution, give Crofton Convalesc				r Location of Death	1	4c. County of Dea	
	Funeral		5. Social Security Number 6. S		rs. last birthday)	Crofton If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Anne Art	ndel thplace (State or Foreign ountry)
	Director		135-18-4910	□M 2 X]F	83 Yrs.	Months Days	Hours Min.	(Month, Day 12/07/1		Jersey
	and *		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Maryl f sho	tor	Maryland Anne Aru	ndel (Crofton					1 XYes 2 No
	r 28a	Director	10e. Street and Number	1401	, LOI COII	10f. Zip Code			10g. Citizen of What C	ountry?
	23a c		1558 Bandury Cour	rt		21114			USA	
	tems	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	I', or I	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 🎾 No	Specify:		Specify:	+0
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examinar must be notified at	ted	15. Decedent's Ed	lucation		dent's Usual Occup			16b. Kind of Business	/Industry
215	ithin 7	Completed	(Specify only highest gra	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most of wor.	king	Curtiss Wi	
2	filed w I Hygier other th		17. Father's Name (First, Middle, Last)	1	Secre	tary	19 Mathada Nam	o (First Middle	Airplane I	arts
and	d be fantal h	o Be	Vincent Guzoski				Mary Wil		Maiden Sumame)	
Maryland	shoul and Me mark	2	19a. Informant's Name/Relationship (Type, Print)	19b. Maili				r, City or Town, State,	Zip Code)
	and 2 salth a n 27 ls		Kasmir W. Witkiew	cz/ Husband	1558	Bandury C	ourt Cro	fton, Ma	ryland 211	14
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at QRCs.	l i	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	b. Place of Dispo cemetery, crei	osition (Name of matory or other place	ce)	Date	20c. Location - City o	Town, State
Ħ	trnent of I		*4 □ Donation 5 □ Other (Specify			matory or other place urrection Cemetery		4-2005	Clinton, M	aryland
Ba	permi Depa impo any ir		21. Signature of Funeral Service Lic	9					Evans Fune , Maryland	
			23a. Part1. Enter the disease, or com	plications that caused the d						Approximate
J.	Pnysician		shock, or heart failure. List only Immediate Cause (Final	one cause of ach line.	chid.					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a cons		-				
	Examiner		Sequentially list conditions,	. railu	ue to	thriu	le			
	bed sit	nine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):					
,	te be executed ysicien and ie burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):					
760	a 2 a	cail		. d						
89 >		Med	IF FEMALE:							
Вох	leath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	etel death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
o.	at the de by the a tached	ysic	1 ☐ Yes 2 DNo 9 ☐ Unknown	4□ Pregnant at time o 9□ Unknown	ordeath 5L	Other (specify)				
٥.	s that ned b	by Pt	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
rds	w requires that been signed b should be deta	ed b	Delletia					1 🗆 Y	es 2□No 3□P	robably 4 Unknown
Records,	law relas be	Completed	General	Jesilely				24a. Was a autops	sy prior to	utopsy findings available completion of cause of
		Con						perform 1 Tes	med? death? 2 No 1 ☐ Ye	2 No
<u> </u>	Phyaician: Th r this certificate ral director, pag	Be C	25. Was case referred to medical examiner?	Hospital:		Othe		th (Check only or		
ō	y Physics or this eral di	n: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatier 28b. Time o	IL 3 DOA	Nursing m		ence 6 Other (Spe	ocify)
0	Attending F death. ctor: After y the funer	atio	2 ☐ Accident 5 ☐ Pending investigation) Injury		K? Yes 2 □ No			
Division of Vital	r Atte	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	at home, farm, str	eet, factory, office		28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
2	Hospital or Attending 24 hours efter death. Funeral Director: After tely filled in by the fune		×A	//						
	To the Hospital or Attenc within 24 hours efter death To the Funeral Director: completely filled in by the t	edicai	29a. Certifier Check only 2 dedical Exem	ysician: To the best of my laner: On the basis of exame and manner stated.	knowledge, deat ination and/or in	h occurred at the tin vestigation, in my of	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To the Youthin 2 To the comple	Me	29b. Signature and title of certifier			29c. License	e number	2	29d. Date signed (Mon	th, Day, Year)
						De	57028		12-27	-04
			30. Name and address of person who			Print)				
	- CA	to.	31. Date filed (Month, Day, Year)	PRA, M.D. C. 32. Resitrar's Si	gnature .	claselyAu	e. Ste. 2	314nn	apolis,n	1D.Z1401
	Sta Registr		DEC 28		JA .	Good .				
-			12 A							

State of Maryland / Department of Health and Mental Hygien 0 0 4 42795 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 6:30 AM December 30, 2004 Wilson Lillian Elizabeth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary's Lexington Park 20560 Ridge Road If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2X F Maryland 2, 2001 Director 219-61-6096 Usual Residence of Decedent 10d, Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a. State irai, or items 23a or 28a-f show Examiner must be mailfied at 1 Yes 2X No Lexington Park Directo St. Mary's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 2065<u>3</u> 20560 Ridge Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XNo If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Interportent: if item 27 is marked other then "natural", or iter any injury or other treumatic event, Ite Marical Exer. Ill reports. Never Married 2 Married 1 ☐ Yes XXNo Specify: Baltimore, Maryland 21215-0036 Specify à 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) None 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sandra Johnson Darwin Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20560 Ridge RD., Lexington Park, MD 20653 Sandra Dee Wilson / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) St. Paul's Methodist 01-04-05 Lusby, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee P.O. Box 279 Leonardtown, Maryland 20650 David A. Goff MO1095 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, le cause on each time. 23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final Meningoencephalocele

Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Dav in the past 12 months? 5 Other (specify) Yes 2 **W**0 detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 0 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
1 Yes 2 No 1 ☐ Yes X No Hospitel or Attending Physicien: 26. Place of Death (Check only one) funeral director, Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Tyes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident filled in by the 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitel of within 24 hours all To the Funerel D 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number + 40055751 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Schmidt, M.D. 23415 Three Notch Road California, Maryland 20619 egistrar's Signature 32. 31. Date filed (Month) 2005 State Registrar

			1- State of Maryland / Departmen Certificate Certificate	nt of Health and N te of Death	lental Hygie Reg.		42796
Í			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medi		Julia Crouse Young		Month December	25, 2004	9:50 a M
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City,	Town, or Location of Death		4c. County of Death	
				thersburg		Montgomer	У
	Funeral Director		Months Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp Coul	olace (State or Foreign ntry)
			Usual Residence of Decedent		Oct. 7,	1911	TN
	yland		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	a-f s	ctor	Maryland Montgomery Gaithersburg	,			1 Yes 2 □ No
	or 28	Directo	10e. Street and Number 10f. Zip		10g.	Citizen of What Cour	ntry?
	death with the Maryland ims 23a or 28a-f show I riust to notified at	rai	415 Russell Avenue Apt. 902 208	77	Uni	ited State	S
	er de Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. If Yes, spec	dent of Hispanic Origin? (Spicify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White.	
35	hours after tural', or ite	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No If Yes, Give 1 ☐ Yes 3 🛣 Widowed 4 ☐ Divorced Year or Dates:	25kNo Specify:		Specify:	
21215-0036			15. Decedent's Education 16a Decedent's Usua	al Occupation	161	. Kind of Business/Inc	hite
7	within 72 ene. then "na	Completed	(Specify only highest grade completed) (Give kind of word life. DO NOT us Elementary/Secondary (0-12) College (1-4or 5+)	nk done during most of work	ing	. 11110 01 000110000111	2001iy
	filed wil Hygien other the	Con	2 Nurse			Medical	
and	0 = 0 \$	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	den Sumame)	
\leq	2 should be and Mental is marked eumatic ev	2	Charles Crouse	Alice Ke			
Mar	d 2 sl th and 7 is r treur			(Street and Number or Rura			
a)	Heal Heal tem 2		Robert Daniel Crouse (Nephew) 11027 Becom 20a. Method of Disposition 1 Burisl 2 Micromation 2 Demonstrator 20b. Place of Disposition (Name completely, crematory or of	ntree Lake Ap		Leston, VA	
Baitimor	permit. Pages 1 and 2 should be Department of Health and Menta important: If Item 27 is marked any injury or other treumstic enones.		1 - Buildi 2 McGennation 3 - Nemoval from State				
	mit. Foortar		21. Signature of Funeral Service Licensee	d Address of Facility De	Vol Funer	exandria,	Virginia
ñ	Per im p		The East Gaither	t Deer Park D rsburg, MD 20	rive	ar nome	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or right failure. List only one cause on each line.	e of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between
	Pnysician :		Immediate Cause (Final disease or condition	۵			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):				1 year
	Examiner	_	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of				148ar
	ed	ine	if any leadin, to immediate Due to for as a construence of cause. Enter Underlying Cause (Disease or injury				2
•	al-trar	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):				2 years
00/00	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		d				
00	tificat ig phy as the	ledical	u.				
Š	w requires that the death cert been signed by the attendin should be detached for use	ian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pre	OGDODO:		23d. Date of delive	ry
	e dea he att	hysicia	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (spe			Month	Day Year
	d by t	Phy	3 LI OTINTOWIT				
ords,	ires the signe	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	ause given in Part I.		o use contribute to the	
5	v requ	etec			1 Tes	2 No 3 Proba	
ย	sicien: The law s certificate has b lirector, page 2 s	ompieted			24a. Was an autopsy performed	prior to com	osy findings available apletion of cause of
2	ificate or, pa	e Co	25. Was case referred to medical		1		2 🗆 No
-	ysicien: The is certificate hadirector, page	0.0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO/	26. Place of Death Other: Nursing Hon		6 □Other (Specify,	
5	ig Ph ter th	L:U	27. Manner of Death 28a. Date of Injury 28b. Time of 28		8d. Describe how in		<u>'</u>
5	tending Ph leath. tor: After th the funeral	atic	2 Accident investigation M	1 ☐ Yes 2 ☐ No			
Ä	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	, office 2	8f. Location (Street City or Town, Sta	and Number or Rural	Route Number,
3	pitel ours a erei [200 Codifice (PC) all in Plant	1			
	To the Hospital or Attanding Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director;	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physicien: To the best of my knowledge, death occurred a 2 ☐ Medical Exeminer: On the basis of examination and/or investigation, i and manner stated.	it the time, date and place, a in my opinion, death occurre	nd due to the cause id at the time, date a	(s) and manner as sta ind place, and due to	ited. the cause(s)
	Fo the within Fo the comple	Me	and marino) stated.	License number		Date signed (Month, D	
			ble (2 Mar De ina)	1919294	1	-	*
	3	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	/		c c my or o	1,009
			(John 12. Melnich 911 Russe	:11 Ave. 6	ai theirs	ecember 2 mg, Mol	. 20F79
	Stat		31. Date filed (Month, Day, Year) DEC 2 9 2004 32. Registrar's Signature	w/s/		0,	
	Registra	ar	DEC 20 COUNTY	400			

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	Physici	an	Decedent's Name (First, Middle, JULIUS	Last)	AVE-	LROD					2. Date of Dea Month DECEMB	ath Day	,	Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution,	nive street and numb		LKOD	4h City	Town or	Location	of Death			County o		10:35 A ^M
1	Examir	ier	10401 GROSVENOR					CKVI		OI DeallI			ONTG		27
	Funeral					last birthday)	If Under	1 Year	If Under		8. Date of Birt	h			ace (State or Foreign try)
	Director		056-01-2986 Usuel Residence of Decedent	1 欠 M 2□ F	92	Yrs.	Months	Days	Hours	Min.	MAY 30,	191	.2 N	IEW Y	ORK
	how	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							1	Od. Inside City Limits
	Ba-f e	cto	MARYLAND MONTGO	MERY		ROCKY	VILLE								1 G Yes 2 □ No
	vith th	Dire	10e, Street and Number				10f. Zip					10g. Citi	zen of Wh	nat Coun	try?
	238	Ta.	10401 GROSVENOR					0852					ED S		
36	within 72 hours after death with the Maryland liene. rthen "natural", or Itame 23a or 28a-f ehow Ita: Medical Evantinet med be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 🏋 Widowed 4 □ Divorced	12. Was Decedor Armed Force d 1 Tes 2 If Yes, Give Year or Date	es? X	1	Was Deced If Yes, spec 1 Yes 2				ecify Yes or No- Rican, etc.)			White,	
9	2 hou	bed	15. Decedent's	Education		16a. Deced	dent's Usua	d Occupa	ation			16b. Kir	nd of Busi		HITE
215	within 7. ene. than "n	pie	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4	or 5+)	(Give	kind of wor DO NOT us	k done d e retired	<i>luring</i> mos ')	t of work	ing				,
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yla	Meni Meni arke	2	ISADORE	AXELROD					M	OLLY	7	LEIC	HTLI	NG	
, Maryland 21215-0036	os 1 and 2 should b of Health and Ment f item 27 is marked r other traumatic e		PAUL M. AXELROD								a <i>i Route Numbe</i> IPON, WI			tate, <i>Zip</i> 549	
ore,	of He of He rothe		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	ne of	- 17		Date		cation - C		
Ë	Page nent ant: If	l ,	1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		3(0)	DEAN ME			,	2/31	/2004	OLN	EY,	MARY	LAND
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Li	Dtsta	eny	DA 11	Name and ANZANS L70 RO	Addres	s of Facilit	ERG	MEMORIA , ROCKV	L CH	APEI.	S. I	
П			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that cau	sed the deat	h. Do not ent	er the mode	of dying	g, such as	cardiac	or respiratory arr	est,			Approximate Interval 8etween
	Pnysician	e u	Immediate Cause (Final disease or condition	a. ACUTE										1	Onset and Death HOUR
H	/Medical Examiner		resulting in death)		as a conseq			JII0,	.,						поск
h		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of):								EASE			1	0 YEARS	
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687	ficate physics to the		100	d											
Вох	death certific e attending pl d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								2	3d. Date	of deliver	v
	death e atte	icia	in the past 12 months?	4☐Pregnan			Ectopic pre Other <i>(spe</i>						Month		Day Year
P.0	that the de led by the a detached t	hys	9 Unknown	9L] Unknow	n										
	igned be del	by P	Part II. Other significant condition	s contributing to deat	h but not res	ulting in the ur	nderlying ca	iuse give	n in Part I.		23e. Did to	bacco us	e contrib	ute to the	cause of death?
ecords,	law requires as been sign 2 should be										1 🗆 Y	es 25	No 3	☐ Proba	bly 4 □Unknown
ecc	ne law r has be ge 2 sh	Completed									24a. Was a				sy findings available pletion of cause of
E E	That a steep a	Con									perform		dea	th? Yes 2	
Vital	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospitale				-7-		of Death	(Check only or	10)			
of	Physical this and dir	5	1 ∑ Yes 2 ☐ No 27. Manner of Death			ER/Outpatien			4 🗆 140		me 5 X Reside				
u	ding h. After funer	tion	1 X Natural 5 ☐ Pending	28a. Date of I (Month,	Day Year)	28b. Time of Injury	M 28	Bc. Injury Work	at ? ′es 2∐1		28d. Describe h	ow injury	occurred		
Division	Attanding Physician: r death. actor: After this certific. by the funeral director,	licat	2 Accident investiga 3 Suicide 6 Could no	t be	Injuny - At ho	ome, farm, stre			95 Z [] I		28f. Location (Si	root and	Number	or Rural	Route Number
<u>S</u>	s after s after al Dira	Certification;	4 Homicide determin	building,	etc. (Specify	y)	ser, ractory,	Onice			City or Town		744111067	UI MUI AI	House Number,
	To the Hospital or Attandir within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	edical (29a. Certifier 1X Certifying (Check only one) 2 Medical Ex	Physician: To the be taminer: On the basis and manner	s of examina	wledge, death tion and/or inv	occurred a restigation,	it the time in my op	e, date and inion, deat	d place, th occurr	and due to the co	ause(s) a ate and	and mann place, and	er as sta	ted. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and little of certifier	11	7		29c.	License	number		2	9d. Date	signed (Month, D	ay, Year)
	./		Mauell	Telle	16	11		D13	3818		1	DECE	MBER	30.	2004
	15		30. Name and address of person will	no completed cause of	of death (Item	23a) (Type, I	Print)								_ 0 0 1
			GARY P. FISHER,				AVENU	JΕ, #	730	CHE	VY CHAS	Е, М	D 20	0815	
	Sta Registra		31. Date liled (Month, Day, Year) JAN 0 3	2005 32. 309	strar's Signa	ture of	sale)								

			For State Registrar	State of Maryland /	Department of Certificate of		lental Hygier Reg. I	711111	42798		
			Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death		
	Physici: /Medic	al .	Aubrey		erson, Sr.		Dec. 31,	2004	10:33 P ^M		
	Examin	er	4a. Facility Name (If not institution, give s		0.5	n, or Location of Death		4c. County of Death	oongo! c		
	Funeral		15404 Livingston 5. Social Security Number 6. Sex		ACCO	ar II Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	Prince G	place (State or Foreign		
	Director		579-36-1275	^{KM 2□ F} 76	Yrs. Months Da	ys Hours Min.			ginia		
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits		
	Maryli	ţō	MD Prince	George's Acco	okeek				1 ☐ Yes 2 No		
	n the	Director	10e. Street and Number	deorge 5 need	10f. Zip Cod	е	10g.	Citizen of What Cou	ntry?		
	23a c		15404 Livingston		206			U.S.A.			
	er dee Items	Funerai	11. Marital States	12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 No	13. Was Decedent If Yes, specify (ol Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	can Indian, etc.		
336	J within 72 hours after deeth with the Maryland jiene. Than 'natural', or Items 23a or 28a-f ehow I'm Medical Evans er must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates: 1951-56	6 1 ☐ Yes 2 页	No Specify:		Specify: Wh	ite		
2-0	72 hou	eted	15. Decedent's Edui (Specify only highest grade	cation 16	Sa. Decedent's Usual Oc (Give kind of work do	ne during most of work	ing 16b	. Kind of Business/In	dustry		
121	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Carpenter	tired)		Construct	ion		
d 2	file Thys	e Co	17. Father's Name (First, Middle, Last)		carpencer	18. Mother's Name	e (First, Middle, Maiden Sumame)				
ılan	2 to 5 to 5	To B	Hurshel Alley And	derson		Josephi	ne Ann Wr	ight			
Maryland 21215-0036	and and is m		19a. Informant's Name/Relationship (Ty		9b. Mailing Address (Str						
	s 1 and 2 if Health Item 27 other tra		Aubrey Allen Ander	20b. Place	of Disposition (Name o	dy Acres Dr		e, MD ZU Location - City or T	693 own, State		
nor	Pages nent of int: If It iry or o		1 M Burial 2 ☐ Cremation 3 ☐ P '4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	tery, crematory or other terans' Cem	i	-2005 Ch	eltenham,	MD		
Baltimore,	permit. Page Depertment of Important: If any injury or once.		21. Signature of Funeral Service License			Idress of Facility Funeral Hom ox 156, Wal					
8	80 E E 9	1 1	fate 1/teple	in the second the death C	P.O. B	ox 156, Wal	dorf, MD	20604	Approximate		
	N 18		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	re cause on each line.					Interval Between Onset and Death		
1	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence		scular	12 ce	-			
	Examiner		Sequentially list conditions,).							
	ed 11st	liner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dud to (or as a consequenc	58 OT):						
	be executed siclen and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	ce of):						
8760,	cate be executed physiclen and the burial-transit	dicail		j							
9	entifica ling ph	0	IF FEMALE:	172 If we outcome of programmy							
Вох	death certific e attending p ed for use as t	Physician/M	in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death				23d. Date of deliv Month	ery Day Year		
o.	0 0 0	hysic	1 Ures 2 No 9 Unknown	9 Unknown		/					
s, P	The law requires that the tee bas been signed by thoage 2 should be detache	by P	Part II. Other significant conditions con	ntributing to death but not resulting	g in the underlying cause	given in Part I.		co use contribute to			
ord	w requir been si should l						1 Tes		bably 4 Unknown		
Records,	e law has b	Completed					24a. Was an autopsy performed	prior to co	opsy findings available empletion of cause of		
Vital		e Co	25. Was case referred to medical			26 Place of Deat	1 Yes 2	Ae 1 ☐ Yes	2 No		
N N	S S	OB	examiner?	Hospital: 1 Inpatient 2 ER/	Outpatient 3 DOA	Other	me 5 idence	6 ☐Other (Speci	fy)		
n of	ding Phy h. After the funeral	on: T	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	njury at Work?	28d. Describe how in	njury occurred			
Division	Attending in death. ector; After by the fune	icati	2 Ccident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home,		1 ☐ Yes 2 ☐ No	28f. Location (Street	and Number or Rur	al Route Number.		
Div	in State	Certification;	4 Homicide determined	building, etc. (Specify)	, raini, street, ractory, on		City or Town, Si				
	To the Hospital or within 24 hours after the Funeral Dil completely filled in	edicai C	29a. Certifier (Check only 2 dical Exami	sician: To the best of my knowled ner: On the basis of examination	dge, death occurred at the and/or investigation, in a	ne time, date and place, my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as and place, and due to	stated. o the cause(s)		
	thin 2, the formula the formul	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. Lic	cense number	29d.	Date signed (Month,	Day, Year)		
	F≯Fŏ		Koni	M Malt.	S	12435	2	1/3/05	_		
-	LA MG	11	30. Name and address of person who co	impleted cause of death (Item 23:	a) (Type, Print)	Plate A	^^ `	0111			
1	71 14	IVI	31. Date liled (Month, Day, Year)	32. Registrar's Signature		11cto	7	0646			
	Sta Registi			2005 Marie							

			1 - For State of Maryland / Departs Registrar Certif	ment of Health and Me licate of Death	ental Hygien Reg. N		42799
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		Janice G. Angell		Dec. 27,	2004 Year	7:05 p ^M
	/Medio			o. City, Town, or Location of Death	4	c. County of Death	
			28613 Club House Drive	Easton		Talbot	
	Funeral		S. Social Security (Valides)	Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year	9. Birthp	place (State or Foreign
	Director		103-18-9506 79 Yrs.				York
	pue *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati	on		1	10d. Inside City Limits
	Aarylu I sho	ь	Maryland Talbot	Easton			1 Yes 2 No
5	28a-	Director		10f. Zip Code	10g. C	itizen of What Cour	ntry?
Ĺ	with Sa or		28613 Club House Drive	21601		USA	
3	ns 2	Funeral		Decedent of Hispanic Origin? (Speces, specify Cuban, Mexican, Puerto R	rify Yes or No-	14. Race - Americ	
9	or Ites		1 ☐ Never Married 21 ☐ Married 1 ☐ Yes 2 ☐ No	/	lican, etc.)	Black, White,	etc.
සු	ral', c	ğ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Yes 2. Mo Specify:		Specify: Whi	te
2-0	be filed within 72 hours after death with the Maryland hat Hyglene. od other than "natural", or Items 23a or 28a-f show event, the Madical Exartiret must be notified at	Completed	15. Decedent's Education 16a. Decedent (Specify only highest grade completed) (Give kind	's Usual Occupation d of work done during most of working NOT use retired)	g 16b. I	Kind of Business/In	dustry
21	within ene. than "	mpi	Elementary/Secondary (0-12) College (1-4or 5+)			0 0	
2	e filed within al Hygiene. other than vent, the Ma		12 Sec	cretary	(First, Middle, Maide	<u>S. Govern</u>	ment
Maryland 21215-0036	d be find he dollar	Be c	Fay Grover		ha Terwil		
2	2 should be and Mental is marked o	ဥ		address (Street and Number or Rural			Code)
	요든다구			Club House Drive	, Easton,	MD 2160)1
e,	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic		20a. Method of Disposition 20b. Place of Disposition cametery, cremator	on (Name of Da	ate 20c. l	ocation - City or To	own, State
Ę	Page ient o nt: If rry or	1	1 Burial 2 MCremation 3 Li Removal from State	Cremation Center	12/29/04	Cambrid	le. MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21 Signature of Funeral Service Licensee 22. Na	ame and Address of Facility		D A	140 In 140
<u>m</u>	88 2 8 8		golfee Attres Jonwell 308	ran-Bromwell Fun B High St., Cambr	idge, MD	'21613	
			23a. Part . Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	,			Approximate Interval Between
	Physician -		Immediate Cause (Final disease or condition a Chronic obstruct	tive Pulmonai	ry Disea	236	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				1
	LXammo	<u>.</u>	Sequentially list conditions, Due to for as a consequence of the conditions of the				
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury				
<u> </u>	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last				
8760,	ysicia e bur	dicai	d				
	± 0 €	ledi			3112		
Вох	death certific e attending p ed for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ect	opic pregnancy		23d. Date of delive Month	ery Day Year
Ö.	0 0 0	Physician/Me	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 1 □ Yes 2 No 9 □ Unknown	her (specify)		WOITH	Day Toal
P.0	d by t	Phy	Part II. Other significant conditions contributing to death but not resulting in the under	thring cause given in Part I	23e Did tobacco	use contribute to the	ne cause of death?
ŝ	Se ng	i by	Patti. Otto significant conditions continuing to deal for not resulting in the under	llying cause given in ratti.		2 □ No 3 □ Prob	
Records,		etec			24a. Was an	24h Were auto	psy findings available
Rec	e las has je 2	Completed			autopsy performed?	prior to con death?	mpletion of cause of
_	iclan: Th certificate rector, pag	e Co	25. Was case referred to medical	26. Place of Death	(Chack anti and	o 1 ☐ Yes	2 No
\equiv	Phyaiclan: this certific ral director,	0 8	examiner? Hospital:	Other	e Residence	6 □Other (Specifi	v)
		\vdash	27. Manner of Death 28a. Date of Injury 28b. Time of		3d. Describe how inju		,
0	Attending I r death. ector: After by the funer	atio	12 Natural S Foliding	M 1 Yes 2 No			
Division	I or Attendate after death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	Bf. Location (Street a City or Town, Stat		l Route Number,
0	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the						
	Hosp 24 hor Fune Tely fi	edicai	29a. Certifier (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or investione) and manner stated.				
	o the o the	Me	29b. Signature and title of ceptifier	29c. License number	29d. Da	ate signed (Month,	Day, Year)
)	⊢s⊢ō		My for land my	H006078	25	12/28	104
			30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	1)		/	. ,
			Martin Forcest DO 503	Crnwood Driv	re Eas	ton n	1 D
	Sta	100	30. Name and address of person who completed cause of death (Item 23a) (Type, Printing of the Control of the Co	K a	•		
	Registr	ar	The second of the second				

			For State Registrar		State	of Maryl		artment of I rtificate of	Health and M * <i>Death</i>		giene Reg. No.	04	42800
	Physici	an	1. Decedent's Name	(First, Middle, La	ist)					2. Date of De Month	ath Day	Year,	3. Time of Death
	/Medi		Ola Jane							12	28	2004	2:26 pm
	Examir	ner	4a. Facility Name (If I					4b. City, Town, Lanhar	or Location of Death			ounty of Death	
			Doctors C 5. Social Security Nui		y Hospi		yrs. last birthday			P. Date of Ric		ince Ge	
	Funeral Director		579-30-69 Usual Residence of D	949	1□ M 2√2 F	100		Months Days		8. Date of Bir (Month, Da 10/22)	7904	Sout	place (State or Foreign ntry) h Carolina
	with the Maryland s or 28s-f show Le coulded at			10b. County		10c.	. City, Town or L	ocation					10d. Inside City Limits
	Ba-f s	Director	Md.	P.G.				Bowie					1 Yes 2 No
	ith th	Die	10e. Street and Numi		_			10f. Zip Code	00515			n of What Cou	ntry?
	s 23e	ral	12125 Lo	ong Riag	_				20715			J.S.A.	
7	within 72 hours after death with the Maryland ene. Than "natural", or tems 23a or 28a-f show he Medical Evantiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4	_	Armed F	2 KNo	n U.S. 13.	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Spe ban, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)		pacity.	
5-0	72 ho	Completed	(Specifi	15. Decedent's E y only highest gr	ducation)	16a. Dece	dent's Usual Occu	pation during most of working d)	na	16b. Kind	of Business/Ir	
2 2	ithin nan "	nple	Elementary/Second			(1-4or 5+)	life.	DO NOT use retire	ed)	ng .			
6. 5	20 E		8th			-		Housekee _l	1				ivate Homes
3 and	be fi	Be	17. Father's Name (F						18. Mother's Name	,		,	
$\mathcal{V} \stackrel{\text{\tiny 2}}{=}$	2 should be and Mental Is marked of sumatic ev	2	Henry 19a. Informant's Nam	Alexand			405. 14. 3	4.1. (0)		phine V			
~ E	s 1 and 2 should be filed Health and Mental Hyg tem 27 Is marked othe		Deloris A.			hter			tand Number or Rura idge Ln., B			rown, State, Zij 20715	Code)
ie.	item 27 l	1	20a. Method of Dispo	sition		20	b. Place of Disp	osition (Name of matory or other pla		ate		ition - City or To	own, State
	Pages nent of int: If it		1 XBurial 2 ☐					Mem. Parl	1 1	5	Lando	over, M	d.
Baltimore,	permit. Pages Department of I Important: If it any Injury or o		21. Signature of Fund	eral Service Lice	nse	TI	2	2. Name and Addre H.S.Wash:	ess of Facility ington & S	ons Co.	,Inc.		
			23a. Part1. Enter the	disease, or com	plications that	caused the d	leath. Do not en	925 Burro ter the mode of dyi	oughs Ave. ing, such as cardiac o	r respiratory a	Vash., rest.	D.C. 2	Approximate
	Physician /Medical		Immediate Cause (F disease or condition resulting in death)	inal					DIAC F			7/A	Interval Between Onset and Death
	Examiner			- 1	LJUB 10	(or as a cons	sequence or):	YOPA					
	7 -	ner	Sequentially list conditions, leading to immorause. Enter Underly Cause (Disease or in	ditions, nediate	b. Due to		sequence of):	101	1119				
	acuted Ind transi	Examiner	that initiated events	_	С.								
68760,	tificate be executed g physician and as the burial-transit		resulting in death) La	isi	Due to	(or as a cons	sequence of):						
387	physic	edical		•	d						-		
×	certifi Iding Ise as		IF FEMALE:		23c. If yes, ou	tcome of pre	gnancy				1 00-	4 D-44 d-2	
.O. Box	Attending Physician: The law requires that the death cert r death. octor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	by Physician/M	23b. Was decedent p in the past 12 m 1 Yes 2 Unknown	nonths?	1 ☐ Live	birth 2 ☐ F nant at time o	etal death 3[Ectopic pregnanc Other (specify)	y		230	d. Date of delive Month	ory Day Year
s, G	es thai gned b	by P	Part II. Other signific	ant conditions	contributing to d	leath but not	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use	contribute to ti	ne cause of death?
ord	v requires been sign should be									101	'es 2 🔄	No 3 Prob	ably 4 Unknown
Division of Vital Records, P.O.	The law rate has be page 2 sh	Completed										24b. Were auto prior to co death? 1 \(\text{Yes}	psy findings available mpletion of cause of 2 No
/ita	tending Physician: The feath. tor: After this certificate the funeral director, pag	Be	25. Was case referre	d to medical					26. Place of Death				
of (hysi this c	2	1 Yes 2 N				ER/Outpatie	IL SELDOA	her: 4 Nursing Hon				r)
, u	Jing F	lon:	27. Manner of Seath 1 Matural	5 Pending		of Injury ith, Day Year	28b. Time of Injury	Wo		8d. Describe t	iow injury o	occurred	
isic	ttendi death. ctor: A / the fu	Icat	2 Accident 3 Suicide	investigatio	e Geo Binos	of Injuny . A	t home farm et	M 1]Yes 2 No	Rf Location /	Stroot and A	Jumber or Dura	I Route Number,
Div	at or Attent after deat I Director: d in by the	Certification:	4 Homicide	determined	build	ing, etc. (Spe	ecify)	eet, factory, office		City or Tov	in, State)	eamber of Adra	r nodle ramber,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 (Check only 2 one) 2	Certifying Pl	niner: On the b	best of my leasis of exam	knowledge, deat ination and/or in	h occurred at the til vestigation, in my o	ime, date and place, a opinion, death occurre	nd due to the o	cause(s) an date and pla	nd manner as s ace, and due to	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and tit	tle of certifier		<u></u>	Δ	29c. Licens	se number		29d. Date s	signed (Month,	Day, Year)
			20 No.		,			D D 5	58182	1	2-	30-	04
CF			30. Name and address	eorge	, 730	5A /	Hanou	OV	14, Gree	enbeli	L mi	0 26	04
	Sta Registr		31. Date filed (Month,			Registrar's Sig	gnature Apa	de la company de					

			1 - For State Registrar	State of M	aryland	-	artmen rtificat			and M		Reg. No	000	Western A.	2801
	Physic /Medi		Decedent's Name (First, Middle, La CYNTHIA JEAN								2. Date of De Month DECEME		′31 Ž	ear 0041	0:10PM
	Examii	ner	4a. Facility Name (If not institution, given NATIONAL INSTI	TUTES OF			BET	THES				М		OMERY	
	Funeral Director		307 04 0747	Sex 7. Ag 1 □ M 2√√x fx	e (In yrs. Ia 44	ast birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bir 05/11/1	1960	9	i. Birthplace (Country) Texas	State or Foreign
	72 hours after death with the Maryland netural; or Items 23s or 28e-f show iteal Examiner must be neitified at	Director	Usual Residence of Decedent 10a. State 10b. County D. C. 10e. Street and Number			,TownorLo shingt						10- 64			side City Limits
	s 23a or	erai Dir	2975 Ft. Baker I		5				200				USA	A	
980	ours after de ral', or Item Examiner	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes XXII If Yes, Give Year or Dates:			Was Deced fYes, spec 1 ☐ Yes		spanic Ori n, Mexican Specity:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.))-		American Inc White, etc.	White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 28e-f show any injury or other traumetic event, the Musical Examinet must be notified at once.	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)		i+)	16a. Deced (Give life. I Teac	kind of wo DO NOT us	al Occupa rk done d se retired,	ition Juring most	of worki	ng		nd of Busin ucati	ness/Industry	
Maryland 2	ould be filed Mental Hyg arked othe etic event,	To Be C	17. Father's Name (First, Middle, Last G.H. Brister	==1,1=3,963					Ila	M. 1	(First, Middle, Roesche	ib			,
e, Mar	and 2 sho lealth and m 27 is ma		19a. Informant's Nama/Relationship (Terry Marek / Fri		OOL DI	2975	Ft.	Bake		ive S	S.E. Wa	shin	gton,	DC 2	20020
Baltimore,	t. Pages 1 rtment of P rtant: If ite njury or ot		20a. Method of Disposition 1 □ Burial 2 □ □ remation 3 □ '4 □ Donation 5 □ Other (Special Control of the Con	(y)	Ce	ace of Dispo metery, crem as Cre	matory or o mator	ther place . Y	Ja	an.4		Edge	water	y or Town, S , Mary	land
Ba	permi Depa Impo any ir		23a. Party Enter the disease, or com	de	the death	6 Do not cet	160 C	Geor Seor Son	ge P	Ka.	Las Fun Oxon H	eral	Home Mary	P.A. land 2	0745
	Pnysician /Medical Examiner		shoot, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	10.	dial				cardiac c	respiratory as	rrest,		Onse	oximate val Between it and Death
	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as	a SunSeque	ance of).	enal	olis	euse					-34	lears
P.O. Box 68	ne death certifi the attencing I thed for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☑ Onknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal o	death 3 🗆	Ectopic pro					2	3d. Date o Month	f delivery Day	Year
rds, P.	quires that It n signed by uld be detac		Part II. Other significant conditions of	contributing to death be	ut not result	ting in the ur	nderlying ca	ause give	n in Part I.			obacco u res 2	/	te to the caus	se of death?
al Reco		Completed								_		an sy rmed? 2 \(\) No	prior deat	r to completic	dings available in of cause of o
Division of Vital Records,	ding Ph h. After th funeral	ation: To Be	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatie 28a. Date of Injur (Month, Day		R/Outpatient 28b. Time of Injury		Bc. Injury Work	r: 4 🗆 Nur	sing Hon	Check onl on the 5 Resid	ience 6		Specify)	
Divis	To the Hospitel or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be determined	building, etc	. (Specify)						8f. Location (S City or Tow	m, State)			e Number,
	To the Hospitel or within 24 hours afte To the Funeral Director Completely filled in the formulation of the	Medical	one) 2 Medical Exar	ysician: To the best on niner: On the basis of and manner sta	examination	ledge, death on and/or inv	estigation,	in my op	inion, deatl	l place, a	d at the time, o	date and	place, and	due to the ca	
)	Z 1 1 8		29b. Signature and title of certifier					License	57(19	Ma	yland	∠au. ∪al€	12 3	fonth, Day, Y	
R	(8)			DEANS		10 CE		R DR	IVE,		THESDA	, M.	ARYL	AND 2	0892
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registra	ir's Signatu	long	10								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 2:40 P M James Jalett Bailey, December 29, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1**X** M 2□ F Yrs. 87 Director 248-07-7004 South Carolina June 6, 1917 Usual Residence of Decedent with the Maryland 10c. City, Town or Location private: it item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, ite Medical Examinations is notified at it. 10a State 10h County 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death 20902 Funeral 1105 Lamberton Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after C Department of Health and Mental Hygiene. Important: if tiem 27 is marked other then "natural", or Itar Important: if tiem 27 is marked other then "natural", or Itar my jointy of other traumatic event, Ita Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Restaurant Chef 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Not Available 2 Theresa Smalls 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Lee Bailey/Wife 1105 Lamberton Drive, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 30 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 2004 Alexandria, Virginia ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc Will EBor 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Priysician 111 ICCZYOU disease or condition resulting in death) /Medical Due to (of as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law raquires that the death certificate ba exacuted Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. detached ۾ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by pg 1 Yes 2 No 3 Probably 4 Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan certificate has autopsy performed? 2 🗌 No Division of Vital 1 Yes 21 NO 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 ₹No 2 this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ပ္ 2056153 Mulles ELISTIE D MUAK se of death (Item 23a) (Type, Print) address of person who completed ca 32 Degistrar's Signature 31. Date filed (Month, Day, Year) State 03 2005 Registrar

			1 - For State Registrar	State of Ma		Departmen Certificate			and M	F	Reg. No.	04	42803	3
	Physici /Medi			elia	Bourc					2. Date of Dea Month December	Day 22.	Year 2004	3. Time of Death	1
	Examir	er	4a. Facility Name (If not institution, give Kensington Garden: 5. Social Security Number 6. Se	s Nursing	Home	Kens	sing			8. Date of Birtl	Mon	tgome	rv	
	Funeral Director	Į	118 46 2828 Usual Residence of Decedent	M 2☐F		Yrs. Months	Days	Hours	Min.	(Month, Da)	/, Year)		place (State or Foreign ntry) aiti	_
	Maryland f show	tor	10a. State 10b. County D. C. None		10c. City, Town	or Location	D.C	_					10d. Inside City Limits 1 A Yes 2 □ No	
	with the a or 28a	Direc	10e. Street and Number			10f. Zip	Code				10g. Citizen o	f What Cou	ntry?	
9036	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23a or 28a-f show ont, the Medical Examination motifies at	d by Funeral Director	1760 Euclid Stre	12. Was Decedent B Armed Forces? 1 Tyes 2 1 1 If Yes, Give Year or Dates:	Ever in U.S.	13. Was Deced	lent of Hi rify Cuba		gin? (Spe , Puerto F	cify Yes or No- lican, etc.)	14. R	aiti ace - Ameri ack, White,		
21215-0036	ithin 72 h ne. nan *natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5		Decedent's Usua (Give kind of wor life. DO NOT us	rk done d se retired	ation during most)	t of workin	g	16b. Kind of			
nd 21	oe filed wal Hygier d other the	Be Cor	12 17. Father's Name (First, Middle, Last)			Homema	aker	18. Mothe	r's Name	(First, Middle,		n Home	2	_
Maryland	should trud Ment marked umetic	인	Barnave Florimono 19a. Informant's Name/Relationship (7)		19b.	. Mailing Address	(Street a		tulia or or Rural	-	dreau r, City or Tow	n, State, Zij	o Code)	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan be set of the set of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show eny injury acother treumette event, the Medical Exam ner must be notified at one.		resulting in death)	Removal from State	Gate of the death. Do note.	Disposition (Namy, crematory or or of Heaver 22. Name an 11800 not enter the modernt 1a	ne of ther plac 1 Ce1 d Addres	neter ss of Facility	y 12, Hine Shire	30/04 s Rina	20c. Location Silver Idi Fur ilver	Sprin Sprin neral	D.C. 2000 bwn, State Dg. Maryla Home Dy. MD 20904 Approximate Interval Between Onset and Death Onset and Death	n
Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	VMedical Examiner	if any, leading to immediate cause. Enter Underlying Causa, Listander Injury that initiated events resulting in death) Last	Due to (or as a	a consequence of a consequence of pregnancy						23d D	ate of delive	an.	
.O.	that the death led by the atter detached for u	Physician/Me	in the past 12 months? 1 □ Yes 2 ♠No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		3 □Ectopic pro 5 □ Other (spo						Ionth	Day Year	
rds, P.	quires that n signed b uld be deta	by	Part II. Other significant conditions co	ntributing to death bu	it not resulting in	the underlying ca	ause give	en in Part I.			bacco use coi		ne cause of death?	
Vital Records,	icien: The law requires that the death certific certificate has been signed by the attending p rector, page 2 should be detached for use as i	e Completed	25. Was case referred to medical								med? 2 No	prior to co death?	psy findings available mpletion of cause of 2 No	
Division of Vit	ding Phys n. Atter this funeral dii	Certification: To Be	examiner?	Hospital: 1 ☐ Inpatier 28a. Date of Injur (Month, Day	y Year) 28b. T	ime of 20 njury M	8c. Injury Work	er: 4 X Nur	rsing Hom 2	(Check only or e 5 Reside 3d. Describe he	ence 6 00 ow injury occu	ırred		-
D	spitel or Attenours after deathours after deatherel Director:		4 Homicide determined	28e. Place of Inju building, etc	ry - At home, far . (Specify)	rm, street, factory	, office		2	3f. Location (Si City or Town		nber or Rura	I Route Number,	
	Hoy How	edical	29a. Certifier TC Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of ner: On the basis of and manner stat	examination and	, death occurred a Vor investigation,	at the tim in my op	e, date and pinion, deat	d place, at h occurre	nd due to the c d at the time, d	ause(s) and m ate and place	nanner as si , and due to	tated. the cause(s)	
)	To the complet	Σ	29b. Signature and title of certifier		mo			number 53828			9d. Date sign Decembe			
			30. Name and address of person who co				Whe	aton.	Marv	1and 20	0902			_
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 3 2			Sparle			ımı y	imu 2	,,,,,			

			1 - For State Registrar	State of Ma	aryland / [artmen rtificate					jiene leg. No. 0	0 ls	42804
	Physici /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Helen		Br	iggs	3				2. Date of Dea Month Dec • 28 •	Day	Year	3. Time of Death 11:25p
	Examir		4a. Facility Name (If not institution, give		reet and number) 4b. City, Town, or Location of Death						DEC . 20 .	4c. Cour	nty of Deat	h
	Funeral		5410 Grove Stree 5. Social Security Number 6. Security Number	7. Ag	e (In yrs. last bii	rthday)	If Under	1 Year	Chas If Under	24 Hrs.	8. Date of Birth)	1tgome 9. Birth	ery hplace (State or Foreign untry)
	Director		578.62.4426	м 2 ХХ	91	Yrs.	Months	Days	Hours	Min.	(Month, Day Jan.8,			rginia
	nyland how		10a. State 10b. County		10c. City, Tow									10d. Inside City Limits
	ath with the Marylan 23a or 28a-f show	Director	DC None		Wa	shi	ngton							1 ☐ Yes 2X No
	3a or		10e. Street and Number 4721 Tilden Street	t. N.W.			10f. Zip	200	16			0g. Citizen o		untry?
36	or items	by Funeral		12. Was Decedent Armed Forces? 1 Yes 2000 If Yes, Give Year or Dates:	Was Deced f Yes, spec 1 ☐ Yes 2	ent of His		gin? (Spec n, Puerto R	cify Yes or No- lican, etc.)	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White				
Maryland 21215-0036	i within 72 hours jiene. r than "natural", Ine Madical Ex	Completed	15. Decedent's Edu (Specify only highest gradi Elementary/Secondary (0-12)	cation		16a. Decedent's Usual Occupation (Give kind of work done durnlife. DO NOT use retired)			tion uring mos	t of working	g	16b. Kind of	16b. Kind of Business/Industry	
121	e filed w Il Hygier other th		17. Father's Name (First, Middle, Last)	5+		Hor	nemak		18 Mothe	r's Name	(First, Middle,		wn Ho	ome
land	uld be filed fental Hyg rked othar	To Be	Frank Fade	len					16. MOUTE		nerine		ame)	
Mary	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve once.		19a. Informant's Name/Relationship (Ty Helen McNeal/ Daugh							er or Rural	Route Number	, City or Tow		lip Code)
Baltimore,	es 1 ar of Hea of Hea fitem frothe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	20b. Place of	f Dispo		e of		Da		20c. Location		Town, State
ţi	rtment rtant:		'4 ☐ Donation 5 ☐ Other (Specify)		Arling					an.19	,2005	Arling	ton,	Virginia
Bal	Depa Impo any ir		21. Signature of Funeral Service License 23a. Part1 Enter the disease, or compli	1500	/	51	.30 W	Lscor	ısin	Avenu	ph Gaw	DC 200		Inc.
	Physician pe executed under the principle of the principl	ilcal Examiner	shook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, backing to instruction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	ic Card	of):	opath	ny						Interval Between Onset and Death
.O. Box 6	that the death certificed by the attending properties as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death		Ectopic pre						Date of deliver	very Day Year
s, D	w requires that been signed b should be deta	by	Part II. Other significant conditions cor	ntributing to death b	ut not resulting in	n the ur	nderlying ca	use giver	n in Part I.					the cause of death?
Vital Record	40 00 01	Completed									24a. Was a autops perform	y	prior to co death?	opsy findings available ompletion of cause of 2 No
ō	Attending Physician: The Ir death. actor: After this certificate ha by the funeral director, page	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatie 28a. Date of Injui (Month, Day	ont 2 ER/Outry 28b. 1	itpatien Fime of njury		Other Bc. Injury Work	4 □ Nu	rsing Home	(Check only on e 5 ☐ Reside 3d. Describe ho	ence 6XXX	ther (Spec	Danchter hyresidence
Division	tal or Attencis after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ury - At home, fa c. (Specify)	rm, str	eet, factory,	office		28	Bf. Location (Si City or Town	reet and Nun n, State)	nber or Rui	ral Route Number,
	To the Hospital or Attenvillin 24 hours after deatl To the Funaral Diractor: completely filled in by the	Medical (29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 1 Medical Examination (Check only one)	sician: To the best of ner: On the basis of and manner sta	examination an	d/or inv	occurred a restigation,	it the time in my opi	a, date and nion, deat	d place, an	nd due to the ca d at the time, d	ause(s) and nate and place	nanner as , and due	stated. to the cause(s)
	To the h within 24 To the f complete	Σ	29b. Signature and title of certifier		/2			License			2	9d. Date sign		
7	15		30. Name and address of person who co	impleted cause of d 8200 Prof	eath (Item 23a)	(Туре,	Print)	1661 Suit		/ ₁ To	ndover	Dec. 2		UU4
	C40	•							E 104	+ La	nuover,	нυ Z(1100	<u> </u>
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 3 20	105 See	w B	19	MACH							

			For State Registrar		Pepartment of Health and M Certificate of Death	lental Hygier Reg. I	21111b	42805
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Dav Year	3. Time of Death 8:05 A.M
	/Medio		Deborah Sue Bosw 4a. Facility Name (If not institution, give stre		4b. City, Town, or Location of Death		29, 2004 4c. County of Death	0.03 A.W
			Calvert Memorial Ho	spital	Prince Frederick		Calvert	
	Funeral Director		5. Social Security Number 217-64-9854 Usual Residence of Decedent	7. Age (In yrs. last birth	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Dec. 18,	9. Birth Cou 1954 Wash	place (State or Foreign ntry) ington, DC
	show	j.	10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	r 28a-f	Director	Maryland Calvert 10e. Street and Number	Lusby	10f. Zip Code	10g. 6	Citizen of What Cou	
	th with 230 or	alD	12525 Santa Domingo	Drive	20657	Uni	ted State	es
30	d within 72 hours after death with the Maryland plen. Jen. rhan "natural; or Items 23e or 28e-f show the Modical Examiner must be motified at the Modical Examiner must be motified at	by Funeral	11. Marital Status 12. 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
2-00	72 hour	eted t	15. Decedent's Educati (Specify only highest grade of	on 16a.	Decedent's Usual Occupation (Give kind of work done during most of work	16b.	Kind of Business/In	
Maryland 21215-0036	d withln piene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DO NOT use retired) ninistrative Assista:		stellatio	n Energy
na	be filed tal Hygie d other	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Maid	en Sumame)	
Zia	2 should be to and Mental I amarked or reumatic eve	၉	Rufus Doyle Boswell 19a. Informant's Name/Relationship (Type,		Mailing Address (Street and Number or Run	n Hannah M		Codal
	s 1 and 2 should be filed if Hoalth and Mental Hyg If Health and Mental Hyg Item 27 is marked othe other treumatic event,		Robert Shively (Sor		525 Santa Domingo Dr	ive, Lusby	, Marylar	ad 20657
aitimore,	ages 1 and 2 int of Health t: If Item 27 i		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rem	cemetery	Disposition (Name of v, crematory or other place)		Location - City or To	
Daill	permit. Pages: Department of H Important: If Ite any injury or ot		21. Signature of Funeral Service Licensee	rectop	22. Name and Address of Facility Rate Broomes Island Rd.,	usch Funer	al Home,	P.A. 4405
			23a. Part1. Enter the disease, or complicat	ions that caused the death. Do no	ot enter the mode of dying, such as cardiac			Approximate
ı	Physician		shock, or heart failure. List only one of Immediate Cause (Final disease or condition		PHIC LATERAL	SCLERO	SIS	Interval Between Onset and Death Z - 3 YEAR
	/Medical Examiner		resulting in death)	Due to (or as a consequence o				
l.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to or as a consequence of	f):			
	cate be executed physician and the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence o	n.			
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	ndiflicat ing phy e as th	Medi	IF FEMALE:					
O. Box	that the death certific, ed by the attending pł detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 of onths? 1 ☐ Yes 275 No 9 ☐ Unknown	If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ery Day Year
7	The law requires that the ste has been signed by th page 2 should be detache	by	Part II. Other significant conditions contrib	outing to death but not resulting in	the underlying cause given in Part I.		o use contribute to the	
Vital Records,	The law re- ate has bee page 2 sho	Completed				24a. Was an autopsy performed?	prior to co death?	psy findings available mpletion of cause of
Z	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	nital:		(Check only one)	-	
IO UC	ding Phys n. After this funeral di	tion; To	Natural 5 Pending	28a. Date of Injury 28b. Ti		me 5 Residence 28d. Describe how in		ý) -
DIVISION OF	= 00>	Certification;	3□ Suisida 6□ Could not be	28e. Place of Injury - At home, far building, etc. (Specify)		28f. Location (Street: City or Town, Sta		al Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical C	29a. Certifier (Check only one)	an: To the best of my knowledge, On the basis of examination and and manner stated.	death occurred at the time, date and place, Vor investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as s nd place, and due to	tated. o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c. License number		ate signed (Month,	
			1the	m	040370	/	2/30/09	4
	20		30. Name and address of person who comp	ewski mo	Prince front	enck o	00G CM	078
	• Sta Registr		31. Date filed (Month, Day, Year) JAN 0 3	32. Registras Signature	the Speller			

			1 - State of Maryland / Department	artment of Health and Me rtificate of Death	ental Hygier Reg. r	
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici		Richard Effinger Barton, Sr.	D		2004 Year 2:05 PM
н	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
н			1901 Quiet Meadow Ct.	Huntingtown MD, 2	20639	Calvert
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	B. Date of Birth (Month, Day, Yea March 31,	9. Birthplace (State or Foreign Country)
	Director		250–09–5090 X□M 2□F 87 Yrs.	Monato Sayo House Main.	larch 31,	1917 Öhio
	pur &		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le	ncation		10d. Inside City Limits
	sho	5				1 ☐ Yes 2½ No
	the N	Director	MD Calvert Huntin	gtown 10f. Zip Code	100 /	Citizen of What Country?
	with		1901 Quiet Meadow Ct.	20639		U.S.A.
	72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show olical Examiner must be notified at	Funeral	The state of the s	Was Decedent of Hispanic Origin? (Speci		14. Race · American Indian,
•	fter d	필	Armed Forces?	tf Yes, specify Cuban, Mexican, Puerto Ri	ican, etc.)	Black, White, etc.
5-0036	hours after turel', or Ite al Examine	by	1 ☐ Never Married 2 ☑ Married 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🙀 No Specify:		Specify: White
Ž	hin 72 ho a. an "natur Medical I	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b.	Kind of Business/Industry
Z	within 72 ene. than "nai	ple	(Specify only highest grade completed) (Give life.	kind of work done during most of working DO NOT use retired)	7	
7	or th	Con	2 Prin		Fed	COVCITATION
Maryland	be filed ntal Hygi ed other event, I	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maid	en Sumame)
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a	s 1 and 2 should f Health and Mer flem 27 ia marke other traumatic	. 7		ng Address (Street and Number or Rural I		1
	and eaith m 27 ner tr		Dorothy Barton (Wife) 1901	Quiet Meadow Ct. H	untingto	wn MD, 20639
9	iges 1 a nt of Hea if Item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre-	osition (Name of Date of Mattery or other place)	te 20c.	Location - City or Town, State
altimore,	Pa ant ury		`4 Donation 5 □Other (Specify) Fort Line	coln Cem. Jan. 15	, 2005	Brentwood MD
Ball	permit. Departi Import any inj		21. Signature of Funeral Service diegnsee	2. Name and Address of Facility Lee	Funeral 1	Home Calvert P.A.
_	40599	3 (1)	1900-300	125 SOUTHERN Marvla	and DIVQ.	Owings MD. 20736
			23a. Part1. Enter the disease, or complications that caused the death. Do not en	ter the mode of dying, such as cardiac or i	respiratory arrest,	Approximate
	Physician		Immediate Cause (Finat disease or condition A CUTE	LEUKEMI	A	Per head
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	LEUKEMI plantic Sy	Jam	- Few ments
	LAGIMME	_	Sequentially list conditions, b.	prime 39	Navo-	
11,	ed sit	line	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	v ,		
	and -tran	Examin	that initiated events resulting in death) Last Due to (or as a consequence of):			
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ğ	icate be executed physician and s the burial-transit	lan/Medical	d			
×	wrequires that the death certifi been signed by the attending I should be detached for use as	/Me	IF FEMALE: 23b. Was decaded program: 23c. If yes, outcome of pregnancy	***************************************		Old Data of dalivas
X O D	atten for u	clan	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
j	the d	Physic	1 Yes 2 No 4 Pregnant at time of death 50 9 Unknown			
7	that ed by deta	h Ph	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Kecords,	uires sign ld be	d by	Corenery deling	Deserre	1 🗆 Yes	2 No 3 Probably 4 Unknown
Ö	w req beer shou	lete	0		24a. Was an	24b. Were autopsy findings available
ě	The law ate has b bage 2 st	ompleted			autopsy performed2	prior to completion of cause of death?
VII		e Co	25. Was case referred to medical	00 Plan (19 m) (1 ☐ Yes 2	No 1 Yes 2 No
	Physician: this certific	o Be	examiner? 1 Yes 2 No	26. Place of Death (control of Doa of Death (control of Doa of Do	the state of the s	2 Flores (0-1-7)
0	Phy or this aral d	\vdash	27. Manger of Death 28a. Date of tnjury 28b. Time o	f 28c. Injury at 28	d. Describe how in	
UNISION	th. : Afte	ıtlon;	1. Natural 5 ☐ Pending (Month, Ďay Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
<u>s</u>	Atter r dea sctor	Hice	3 Suicide 6 Could not be	reet, factory, office 28		and Number or Rural Route Number,
5	al or s afte l Dire	Certificati	4 Homicide building, etc. (Specify)		City or Town, Sta	.te)
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	al C	29a. Certifier Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place, and	d due to the cause	(s) and manner as stated.
	n 24 n 24 he Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred	at the time, date a	nd place, and due to the cause(s)
	To t withi To tll comp	Ž	29b. Signature and title of certifier M	29c. License number	29d. D	Date signed (Month, Dey, Year).
			It I Reem Allenda Phys.	LD 19427	1	3/2005
			30. Name and address of person who completed cause of death (Item 23a) Type,	Print) Po	Fredo	MD 20678
_	10+1		HIOMITE	OSP RD. Prince	- 1 / 0400	1000018
	Sta		31. Date filed (Month, Day, Year) 32. Registry's Signature	1 4 -		
	Registr	ar	JAN 0 4 2005 > Bergue, &	GOBATE !!		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** EDWARD BROADWATER DECEMBER 30, 2004 1640 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 MM 2□ F 215-16-4251 84 Vrs Director November 12, 1920 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Maryland Allegany Frostburg 1 Yes 2 No Director 10e. Street and Number 100 Village Parkway Apartment 3 10f. Zip Code 10g. Citizen of What Country? 21532 USA or Items 23a death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 (₹Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status e filed within 72 hours after al Hygiene. other than "natural", or Itel 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify. þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Driver permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy,
Important: If item 27 is marked othe
any Injury or othar traumatic event,
once. 18. Mother's Name (First, Middle, Maiden Sumame) Harriett Catherine Bittinger 17. Father's Name (First, Middle, Last) Be Harmon Grover Broadwater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Winona Leaker/Sister-in-Law 16012 Old Beechwood Road S.W., Lonaconing, Maryland, 21539 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State January 03, 1 Burial 2 □ Cremation 3 □ Removal from State Moscow Mills, Maryland Laurel Hill Cemetery 2005 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home 8 East Main St., Lonaconing, Md. 21539 Msky 23a. Path. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a. ACUTE PNEUMONIA /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last FRACTURED LEFT HIP Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit death certificate be exec Due to (or as a consequence of) Box 68760, (Paul new 340 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 🗷 No 3 Probably page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 1 ☐ Yes 2 No 2 🗆 No 1 Tyes or Attanding Physician: after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 12 Inpatient 2 ER/Outpatient 3 DQA 28b. Time of Injury 28a. Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 5 Pending after death.

Director: Aft in by the fur 1 ☐ Yes 2 🔀 No 2 Accident investigation 1:00 PATIENT FELL ON FLOOR Could no 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) FROSTBURGVILLAGE 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide ASSISTED LIVING HOME FROSTBURG, MARYLAND tha Hospital within 24 hours To the Funeral rtiffing Physician: To the best of my knowledge, beath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical edicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number D17862 JANUARY 3. 2005 3/1UA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MRS 925 SETON DRIVE CUMBERLAND, MARYLAND 21502 DR.SAMUEL HARSKBERGER 31. Date filed (Month, Day, Year 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			State of Maryland / Der State Amend Items 28a-f per ME, G840	partment of Health and						
			Decedent's Name (First, Middle, Last)	Timeate of Death	2. Date of Death	3. Time of Death				
	Physic		Michael Frederick Buckmaster			ay Year				
	/Medi Examii		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	th 40	c. County of Death				
			14 Parkway Drive	Conowingo		Cecil				
	Funeral Director		5. Social Security Number 219-62-3096 6. Sex 1 XM 2 F 7. Age (In yrs. last birthday 51 Yrs.	If Under 1 Year		9. Birthplace (State or Foreign				
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits				
	Many -f sh	ţ	MD Cecil Conowa	10.00		1 ☐ Yes 2 X No				
	r 28a	Funeral Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?				
	th wit	a D	14 Parkway Drive	21918	us	SA				
	ems ems	ner		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puel	Specify Yes or No-	14. Race - American Indian,				
36	s afte		1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☐ No Specify:	to moun, etc.)	Black, White, etc. Specify: White				
00	72 hours after death with the Maryland naturel', or Items 23s or 28s-f show Iteal Examinar must be notified at	ed by	3 Widowed 4 Divorced Year or Dates:							
215-0036	in 72	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	rking 16b. F	Kind of Business/Industry				
212	d within piene. r than "	mo	Elementary/Secondary (U-12) College (1-4or 5+)	puter Technician		Computer				
	e filed al Hygie other vent, li	BeC	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	me (First, Middle, Maider					
<u>a</u>	should bank and Ments	70 5	Frederick Pillip Buckmaster	line Hartman						
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Markeal Examinar must be notified at once.			ing Address (Street and Number or R	ural Route Number, City	or Town, State, Zip Code)				
	l and lealth m 27		Lynn M. Vincer/sister 14	Parkway Drive, Co	nowingo, MD	21918				
Baltimore,	iges intof H		20a. Method of Disposition 1 □ Burial 2 🕱 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	osition (Name of matory or other place) 12-3	0 0001	ocation - City or Town, State				
ij	it. Pa rtmer rtant: njury	.A. R	ising Sun, MD							
Ba	permi Depa impo any ir		21. Signature of Funeral Service Licensee	2. Name and Address of Facility R.	T. Foard Fu	neral Home, P.A.				
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one gayse on each line.	t, Rising S	un, MD 21911 Approximate					
	Physician					Interval Between Onset and Death				
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	Gunshot Wound		immel, at e				
	Examiner		Paracci							
0	p ==	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		year)					
7	and trans									
8760,	be ex cian a	causé. Enter Underlying Causé (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.								
287	physi s the b	dica	d							
Вох 6	leath certific attending p I for use as I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			22d Data of delivery				
m	death e atter	ciar	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year				
P.0	it the d by the tached	hys	9 Unknown							
	res that igned be be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?				
ecords,	w require been sig should b	ted	Alcoholism		1 X Yes 2	□ No 3 □ Probably 4 □Unknown				
	ne law r has be je 2 sh	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
tal R	T P P P P P P P P P P P P P P P P P P P									
Vita	ysician: is certific director,	25. Was case referred to medical examiner? Hospital: Other								
O.	Phys this al dir	2	1 AYes 2 No Hospital: 1 Inpatient 2 ER/Outpatie		lome 5 Residence					
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Division	Atten deat ctor: y the									
Ö	s after all Direction by	erti	4 Homicide determined building, etc. (Specify)	home	City or Town, State	21918 Drive,Conowingo,MD				
	Hospitai 24 hours a Funeral I tely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	h occurred at the time, date and place	and due to the cause(s)	and manner as stated				
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occu	erred at the time, date and	I place, and due to the cause(s)				
	To the Within 2 To the comple	Σ	29b. Signature and title of certifier	29c. License number	29d. Da	te signed (Month, Day, Year)				
			If furks, MD	015314	Deca	ember 28, 2004				
	7		30. Name and address of person who completed cause of death (Item 23a) (Type	. / .						
	Sta	ta	H Farkas MD (Mn IfUsp, /a/, 34. Date filed (Month, Day, Year) 32. Registrar's Signature		-1921					
	Registr		JAN 3 - 2005 31. Date filed (Month, Day, Year) JAN 3 - 2005	and o						

State of Maryland / Department of Health and Mental Hygiene

					State o	f Marylaı			ent of F ate of		nd M		giene Reg. No.	04	42	809
	Physicia	_	1. Decedent's Name (First MARIA C. B		·							2. Date of De Month 12	ath Dey 27	Year 2004		me of Death : 25 AM
1	/Medic: Examine		4a Facility Name (If not in	•		mber)				4b. City, Tow	m, or Loc	etion of Death		unty of Deat		: 25 AM
			Montgomery) If 1.1	nder 1 Year	01ney		- 5 . (5)	1	ntgome		
	Funeral Director		5. Social Security Numbe 577–46–3785	1	ex □M 2∑1F	7. Age (In yrs	. last birthde Yrs.	Mon		Hours	Min.	8. Date of Bin (Month Da 02/13/	1912	9. Birt E1	hplace (S untry) Salva	tate or Foreign
	ylend ************************************	-	Usual Residence of Dece 10a. State 10b.	County		10c. C	ity, Town or	Location						_	10d. ins	ide City Limits
	e Many	cto	MD Mo	ontgom	ery	Si	Lver S	Sprin	g						1 🗆	Yes XXNo
	th with th	ਠ∣	10e. Street and Number 1213 Ednor	Road				10f	Zip Code 20905				10g. Citizer USA	of What Co	untry?	
020	urs e	by Fur	11. Marital Status 1. Wever Married 2 3 □ Widowed 4 □ D		12. Was Dece Armed Fo 1 Tes If Yes, Giv Year or D	re	J,S. 1		ecedent of H specify Cuba s 2 No	Specify		cify Yes or No Rican, etc.)		Race - Ame Black, White ecify: Wh		an,
Maryland 21215-0020	within sne.	Completed	15. D (Specify onl Elementary/Secondary		ucation de completed) College (1	-4or 5+)	(Gi life	cedent's live kind o						of Business/		
2	al Hygie other vent,	Be Co	17. Father's Name (First,	Middle, Last)			nome	шаке	T	18. Mother	's Name	(First, Middle,	Own I			
ylar	D # D .	<u> </u>	Juan Bojor	quez						Estev	ana	Carmona	a			
Man	12 sho		19a. Informant's Name/R					_				Route Number	-		ip Code)	
<u>ත</u>	of Health item 27		Ana Bojorqı 20a. Method of Dispositio		niece)	20b.	Place of Dis	position	(Name of		lver	Sprin	_	20905 ion - City or	Fown, Sta	ıte
altimore,	0 0 = =		1 Burial 2 Cree 4 Donation 5 0	mation 3 D	Removal from				or other place Crema		12	/27/04	Alex	andri	a VA	
Balti	pemit. Peg Depertment Important: I any injury o	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Advent Funeral & Cremation Service Falls Church and Annapolis											ices			
	×	1	23a. Part1. Enter the disc shock, or heart failu	ease, or comp	olications that cone cause on e	aused the dea ach line.									Interva	ximate al Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		a. <u>Sep</u> i											and Death veeks
		<u>ē</u>				Due to (or as a cons	sequence	of):							
·	ficete be executed physician end is the bunel-transit	edicai Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying	is, ate	b. ————	Due to (or as e cons	sequence	of):							
	rificete be ng physicie es the bu		Cause (Disease or injury that initiated events resulting in death) Last	1	C	Due to (d	or as a cons	equence	of):							
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л О	the de yy the e sched f	ıysıc	Part II. Other significant of	conditions co	entributing to de	ath but not res	sulting in the	underlyi	ng cause giv	en in Part I.			_			usa of death?
	s that syned by dete	2											/as 2byl	40 3∐Pr	obably	4 ☐ Unknown
Division of Vital Records,	been s should	Completed										24a. Was perfor	an autopsy med?	a	vailable p	epsy findings brior to n of cause
Î	The l	2										101	es 2.XN	0 1	☐ Yes	2 No
7	sician certifi rector	D	25. Was case referred to examiner?	+	Hospital:		150/0 4		Oth			(Check only o				
on or	Attending Physician: or deeth. ector: After this certific by the funeral director,	or : non:	1 ☐ Yes 2 反 No 27. Manner of Death 1 ☑ Natural 5 ☐ 2 ☐ Accident	Pending investigation	28a. Date of	npatient 2 of Injury h, Day Year)	28b. Time Injury	of	28c. Injur	- INUIS	2	e 5□ Resid 8d. Describe h			afy)	
DIVISI	building, etc. (Specify)								Bf. Location (S City or Tox		umber or Ru	ral Ploute	Number,			
	he Hospital n 24 hours he Funeral pletely filled	29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end manner as st control of the ceuse o									use(s)					
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	State	Ø.	31. Date filed (Month, Day	, Year)	32. P	gistrar's Signa			<i>.</i>		- - - V	Cr Dp.	1119	1111 6	ى ن ر ن	
	Registra	r	UE	0292	.004	STATE OF THE PARTY	A.	5000								

DHMH 16 Rev 6/95

				eartment of Health and Meartificate of Death	ental Hygier	2004 4/810		
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death	_	
	Physici		Wadie M. Brandimore		Dec. 25	$\frac{\text{Year}}{5}$, $\frac{\text{Year}}{2004}$ 1:30 p $^{\text{M}}$		
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	_	
	LAUTINI	CI	FutureCare Chesapeake	Arnold		Anne Arundel		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)) If Under 1 Year If Under 24 Hrs.	B. Date of Birth	9. Birthplace (State or Foreign		
н	Director		405–18–4810 1□ M 2 1 84 Yrs.	Months Days Hours Min.	(Month, Day, Yea Aug. 19,	1920 Country) TN		
	D		Usual Residence of Decedent			1320		
	trylar thow	_	10a. State 10b. County 10c. City, Town or t			10d. Inside City Limits		
	e Ma Sa-f s	cto	MD Anne Arundel	Arnold		1 ☐ Yes 2 No		
	or 2	Dire	10e. Street and Number	10f. Zip Code	10g. 0	citizen of What Country?		
	ath w	Funeral Director	329 Clifton Avenue	21012		USA		
	ar de	nne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Diver Married 2 Maried 1 Diver Married 2 Maried	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.		
36	s afte	by F	If Yes, Give 1054	1 ☐ Yes 2 ☐ No Specify:		Specify: White		
21215-0036	72 hours after death with the Maryland Insturel; or items 23a or 28a-f show deat Examiner must be rediffed at	pa		adoptic Hausi Occupation	166	Kind of Dunions/Industry	_	
Ę.	in 72 n" n	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	7	Kind of Business/Industry		
72	filed within Hygiene. Ithar than "	E O	Elementary/Secondary (0-12) College (1-4or 5+)	Registered Nurse		Hospital		
	filled Hyg othal ant,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maide		_	
lan	should be filed withir nd Mental Hygiene. i markad othar than umatic evant, TIEM	To B	William Miller	Lillie E	. Edwards	3		
Maryland	2 shou and N Is mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ing Address (Street and Number or Rural			_	
Ž	and 2 saith a n 27 is		LeRoy W. Brandimore/Son 8123	Wooded Glen Court,	Ellicott	City, MD 21043		
Baltimore,	itar oth		20a. Method of Disposition 20b. Place of Disposition cemetery, or	osition (Name of Damatory or other place)	te 31 20c.	Location - City or Town, State		
Ĕ	permit. Pages Department of I Important: If its any injury or o			osition (Name of ematory or other place) idge Memorial	004' El	kridge, MD		
alt	permit. Departrimports Imports any inju		21. Signature of Funeral Service Licensee	arranco & Sons, P.A		Park Funeral Home	_	
m	88 2 5 8		Momes & HUM 4	95 Gov. Ritchie Hwy	, Severna	Park, MD 21146		
П			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cau e on each line.	nter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between		
E	Physician		Immediate Cause (Final disease or condition	cancer		Onset and Death		
	/Medical		resulting in death) a. Due to (or as a consequence of):	(ar icer		11011115		
	Examiner		Sequentially list conditions b.					
	p =	ner	if any, leading to immediate Due to (or as a consequence of):					
	ocute nd trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.					
ő	e exe sian a urial-		resulting in death) Last Due to (or as a consequence of):					
8760,	Attanding Physician: The law requires that the death certificate be executed rideath. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	d.				_	
9	artifica ing pt e as t	Mec	IF FEMALE:				-	
Box	ath c	lan/		□Ectopic pregnancy		23d. Date of delivery Month Day Year		
0	the a	/slc	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		month, buy		
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Record	e law has t	Completed	Locon cancer		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?		
	Physician: The la this certificate has al director, page 2				1 ☐ Yes 2	o 1 Yes 2 No		
Vital	ician certifi ector	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check only one)		_	
	Phys this al dir		1 ☐ Yes 2 ☐ No	HIL 3 DOA 4 DATESING HOME		6 □Other (Specify)	_	
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<u>s</u>	death.	ical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s		f Location (Streat	and Number or Rural Route Number,	-	
Division of	l or Attano after deatl Diractor: I in by the	Certification;	4 Homicide determined building, etc. (Specify)	reet, ractory, ornos	City or Town, Sta			
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 ertifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, an	d due to the cause/	s) and manner as stated.		
	e Ho 24 h a Ful	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred	at the time, date a	nd place, and due to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)		
				D50725	1	2-27-04		
	()		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)			_	
			Jenniter Riedinger 8601 Vete	ransthwu Mill	ensy.11	2-27-04 2,MD 21108		
	Sta	te	31. Date filed (Month, Day, Year) 3 Registrar's Signature					
	Registr	ar	DEC 2 9 2004	and I				

		•	, FOI	artment of Health and Mer rtificate of Death	tal Hygien	Z11114
	Dhysisis	90	Decedent's Name (First, Middle, Last)		Date of Death Month , C	3. Time of Death
	Physicia /Medic		Hezekiah Wilbert Berryman	De	cember 2	25, 2004 1:55 p ^M
)	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death Prince George
	Euparal		Southern Maryland Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Clinton If Under 1 Year If Under 24 Hrs. 8.	Date of Birth	Birthplace (State or Foreign
ľ	Funeral Director		227-12-4671 1ÄM 2□F 90 Yrs.	Months Days Hours Min.	(Month, Day, Yea larch 14,	,1914 DC
	pud *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Maryli f eho	ō	W 1 1 D 1	ashington		XXYes 2 □ No
	r 28a-	rect	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	th with	Funeral Director	7504 Blanford Drive	20744	Un	ited States
	ems erre	ıner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1943-	Was Decedent of Hispanic Origin? (Specify f Yes, specify Cuban, Mexican, Puerto Rica	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	by Fu		1 ☐ Yes 2X No Specify:		Specify:
21215-0036	72 hours after death with the Maryland neturel', or items 23a or 28e-f ehow dical Examinational be nulliked at		15. Decedent's Education 16a. Decedent	dent's Usual Occupation	16b.	Black Kind of Business/Industry
215	within 7; iene. then "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)		
7	e filed within al Hygiene. I other then ' vent, Ire Ma		8th Driv	Ve r 18. Mother's Name (F		ederalGovernment
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. I health and Mental Hygiene. I see them 23 or 28e-f ehow tiem 27 is marked other then "netural", or items 23a or 28e-f ehow other traumetic event, I'm Modical Exercine result by rulling at	Ве	17. Father's Name (First, Middle, Last) Hezekiah Berryman		Jones	en Sumame)
Z Z	2 should be and Mental I is marked or aumetic eve	유		ng Address (Street and Number or Rural Re	oute Number, City	y or Town, State, Zip Code)
	alth al		Wilbert Berryman / Son 7504	Blanford Dr. Ft. Was	shington	, Md. 20744
ore,	es 1 and 2 of Health fitem 27 I		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, crem	nsition (Name of Date matory or other place)	20c.	Location - City or Town, State
Baltimore,	Pag tment tent: I jury o		'4 □Donation 5 □Other (Specify) Cedar Hi	11 Cemetery 01-03	-05 Su	itland , Maryland
Ball	permit. Pages 'Department of H Importent: If ite eny injury or of	())	Ant a James MOI OPS 5	. Name and Address of Facility Lexander S. Pope Fu 538 Marlboro Pike F	neral Ho orestvil	
ľ			23a. Part1. Enforthe disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or re	spiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Finál disease or condition resulting in death)	41A		
	/Medical Examiner		Due to (or as a consequence or):	. A		
	72	ler	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	A		
	outed od ransit	Examiner		ALURE		
0,	e exercian ar		resulting in death) Last Due to (or as a consequence of):	Can Marie		
8760,	icate be executed physician and s the burial-transit	edlcal	d RESPIRATOR	RY FAILURE		
9 xo	death certificate be executed e attending physician and of for use as the buriat-transif	n/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	☐Ectopic pregnancy		23d. Date of delivery
O. B	at the deat by the atte tached for	Physician/M		Other (specify)		Month Day Year
σ.	that the		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
rds	quires in signi uld be	ed by			1 🗆 Yes	2 No 3 Probably 4 Unknown
Vital Records,	The law requires that te has been signed b age 2 should be deta	e le			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Œ.		Compl			performed?	? death? No 1 Yes 2 No
Vita	Physicien: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	26. Place of Death (C		
of		1: To	27. Magner of Death 28a. Date of Injury 28b. Time o	f 28c. Injury at 28d	5 Residence Describe how in	6 ☐ Other (Specify) jury occurred
ion	Attending I r death. ector: After by the funer	atlor	1 X Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division	of or Attendia after death. I Director: A d in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	reet, factory, office 28f.	Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	the Hospitel or hin 24 hours afte the Funerel Diru npletely filled in h	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat (Check only one) Certifying Physician: To the best of my knowledge, deat (Check only one)			
	within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	()III		In from Acu	D0057928	12	2/27/04
R	12/1Va		30. Name and address of person who completed cause of death (Item 23a) (Type, MASODD ANWAD 1328 SOUTH	IERN AUE. SE # 21	4 WASHI	METONODC.
H.	Sta Regist		JAN 0 3 2005	EL		

DHMH 17 Rev 1/2001

ended,31, TC	State of Maryland / Department of Health and M I - Registrer Certificate of Death		iene200442812
	1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year 3. Time of Death
Physician /Medical	Gretchen Mae Butler	Dec.	22 2004 0118 ^M
Examiner	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death
	Chestertown Nursing Rehab. Center Chestertown		Kent
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. North Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthplace (State or Foreig Country)
Director	220-32-0037	Aug25,1	932 Maryland
pu &	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limit
aryla sho			1 Tyes 2 No
1215-0036 within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show the Medical Example or neat be notified at ampleted by Funeral Director	Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code	1/	Og. Citizen of What Country?
with t			
Sitter death virtems 23s	402 Morgnec Road 21620 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Vee or No-	USA 14. Race - American Indian,
er de	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 10 No.	Rican, etc.)	Black, White, etc.
21215-0036 ad within 72 hours aft glene. or than "natural", or . It is Medical Exam. Completed by F	3 ⊠Widowed 4 □ Divorced Year or Dates:		Specify: Black
hou hou ed t	15 Decedent's Education 16a, Decedent's Usual Occupation		16b. Kind of Business/Industry
A LA 15-UV A within 72 hou ygiene. In the medical E.	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	ing	
with that the omi	Elementary/Secondary (0-12) College (1-4or 5+) 10 Mail Courier		State of Delaware
be filed d other event,	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, N	Maiden Sumame)
Mental Me	John David Johnson, Sr. Bar	mae Li	.vely
shou mar mar mar mar mar mar mar mar mar mar	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	al Route Number,	City or Town, State, Zip Code)
Maryiano nd 2 should be file lith and Mental Hy 27 is marked oth rtraumatic event	Arliss Commodore / Daughter 6765 Quakerneck Road	.Chester	town, Maryland 21620
BAIRIMOYE, INIGITYIANG ZIZIO-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or Town, State
TO Page ant of the Property of	1 M Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Emanuel UM Church Cem 12-3	0-2004	hakerneck Maryland
Baltimore, bermit. Pages 1 ar Department of Hea mportant: If item any Injury or othe	21. Signature of Funera Pervice Licenses 22. Name and Address of Facility	1	dakerneck, haryland
B F G F F G	21. Signature of Funera Service Cenece 22. Name and Address of Facility Bennie Smith Fune Road 298, Chester	ral Home ctown Mar	vland 21620
	23a. Part1. Ententhe asease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or help failure. List only one cause on each line.	or respiratory arre	est, Approximate Interval Between
8760, rate be executed whysician and the burial-transit the burial-transit fical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. CHRITO Inductions ARRIV. Due to (or as a consequence of): Due to (was a consequence of): C. Due to (or as a consequence of): d.	e with	Aneura
Box 6 ath certific ttending p or use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Division of Vital Records, P.O. I or Attending Physician: The law requires that the deather death. Director: After this certificate has been signed by the a in by the funeral director, page 2 should be detached tertification; To Be Completed by Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Type feeting	23e. Did tob	pacco use contribute to the cause of death? IS 2 No 3 Probably 4 Unknow
VICAL MECOND sician: The law requires certificate has been s lirector, page 2 should o Be Completed		24a. Was an autops perform	y prior to completion of cause of death?
VIta ician: sertifii ector,	examiner?	th (Check only on	
of very signature of the signature of th	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Ho		nce 6 ☐Other (Specify)
Division of Vita tal or Attending Physician: rs after death. al Director: After this certifice ed in by the funeral director, Certification; To Be C	27. Mannprof Death 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Nestigation (Month, Day Year) 1 Nestigation M M M M M M M M M M M M M M M M M M M	LUG. DESCRIBE NO	m injury vocumed
Sic teath tor: / the f	2 Accident	28f Location /St	reet and Number or Rural Route Number,
or Al Miter of Direction by	4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide	City or Town	i, State)
Hospita 4 hours Funeral (ely filled	29a. Certifier (Check only one) 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and manner stated. 2. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the ca red at the time, da	tuse(s) and manner as stated. ate and place, and due to the cause(s)
within 2 To the complet	29b Signa@re and title_of certifier 29c. License number		9d. Date signed (Month, Day, Year)
F3F8	Quelia MA 132669		12/22/04
	Desc, 02367		10100104
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TO Im & AKKABAC TA, MA). 223 Htg & Strue 23. Period of Struet Country C	et che	12/22/04 itentown, Med 21
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 2 8 2	2004	in & foot

State of Maryland / Department of Health and Mental Hygiene State
Registrar amend item#1,QACHD,per dr,1/4/05,16ertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) JAMES HENRY CARR 2. Date of Death 3. Time of Death Physician Day 27 December 1229 --JOHN-----HENRY-----CARR-2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 309 MARGANZA STREET LAUREL PRINCE GEORGES 5. Social Security Number 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** 1**▼** M 2□ F Director 216-60-5976 53 Yrs. SEPT.8,1951 GERMANY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Exprehenment to notified at MD PRINCE GEORGES LAUREL 1 X es 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 MARGANZA STREET 20724 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. hours after 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than College (1-4or 5+) Elementary/Secondary (0-12) BUYER U.S.GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be Ind Mental I is marked "UNKNOWN" FRANCIS OLIVER CARR GISELLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 is m any injury or other traum 2948 BEAVER BROOK CT., PASADENA, MD 21122 MARY CARR/ EX-WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATORY | 12-29-2004 STEVENSVILLE, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ADAMS OF ANNAPOLIS FUNERAL & MEMORIAL CARE Mamas 814 BESTGATE ROAD, ANNAPOLIS, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) e reprovadante **Physician** accid. Nt hrs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underhing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed tran Due to (or as a consequence of): burial-Division of Vital Records, P.O. Box 68760, physicien Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Donknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? certificate 1 TYes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Attanding 1 Natural 5 Pending after death.

I Diractor: Af in by the fur investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 0 within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 Ntesmit 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brue M. Congar MD 205, 11055 Little Potyant Plany 31. Date filed (Month, Day, Year) DEC 2 9 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 00 [42814 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year DECEMBER 29, 2004 **Physician** 11:40A M BRADFORD CUNNINGHAM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner PRINCE GEORGES CHEVERLY PRINCE GEORGES HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex XX M 2 ☐ F **Funeral** Yrs. 19, 1943 SOUTH CAROLINA Director 61 249 68 2573 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ns 23a or 28a-f show XX Yes 2 No Director MARYLAND PRINCE GEORGES SUITLAND 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number UNITED STATES 20746 4715 BROMLEY AVENUE Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 22 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If item 27 is marked other then "naturel", or then ury or other traumatic event, its Medical Extending. 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: BLACK If Yes, Give Year or Dates: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12TH DC GOVERNMENT POLICE OFFICER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROXANNA MINGO ALFONSO CUNNINGHAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a important: If item 27 is eny injury or other trat QDCs. SUITLAND, MD 20746 4715 BROMLEY AVENUE SHEILA BALL / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date XX Burial 2 Cremation 3 Removal from State GEORGE WASHINGTON CEM. 01/04/05 * 4 ☐ Donation 5 ☐ Other (Specify) ADELPHI, MD MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1. Ender the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RESPIRATORY Immediate Cause (Final ODAYS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 15 DAYS NELLHONIA Sequentian, let conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): MOS Hospitel or Attending Physician: The law requires that the death certificate be executed ANCER OF and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? þe Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ been signe should be 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy perform 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1) Natural 5 Pending investigation after death.

Director: Af
d in by the fur 1 Tes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in within 24 hours a To the Funeral 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title-of-certifier 29c License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 GREEN PRINCE GEDRGE'S HOSPITAL LINDA 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 42815 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 29, 2004 **Physician** December 3:45 Рм Selma Elaine Carroll /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F Director 78 MICHIGAN 1926 370-20-3615 Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural; or Items 23a or 28e-f ehow amorphism; propriet treumatic event, the Medical Examinat must be notified at Once. 10a. State 1 ☐ Yes 2 X No Director SILVER SPRING MARYLAND MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BLVD. W. #1413 20902 U.S.A. Funeral 1121 UNIVERSITY 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. 2 WHITE 3 ☐ Widowed 4 K Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ GOVERNMENT SOCIAL WORKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WINEBERG FAYE BENJAMIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20902 19a. Informant's Name/Relationship (Type, Print) 1121 UNIVERSITY BLVD. W. #1102, SILVER SPRING, MD DANIEL B. CARROLL/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State LEBANON CEMETERY 01/02/2005 ADELPHI, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part 1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTASES TO Priysician /Medical Due to (or as a consequence of) **Examiner** NKNOWN MARY Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of) the attending physician Physiclan/Medlcal as the l 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached O 9 Unknown 9 T Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, ed bluods 1 Tyes 2 X No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 Z No Hospital: Other P 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending I within 24 hours after death.

To the Funerel Director: After 1 Avatural 5 Pending investigation 1 Tyes 2 🗆 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my opinion, dark place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 1808 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INESH MONTROSE M.O gistrar's Signature 31. Date filed (Month, Day, Yeer) State JAN 0 3 2005 Registrar

			State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2004	2816								
	Physici /Medic			Time of Death								
	Examin Funeral		1 M 2K F Months Days Hours Min. (Month, Day, Year) Country)	(State or Foreign								
	Director		Usual Residence of Decedent	ngton, DC								
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Maryland	should be filed nd Mental Hygi markad othar umatic evant, L	To Be (17. Father's Name (First, Middle, Last) Michael Emanuel Gramatikos 18. Mother's Name (First, Middle, Maiden Sumame) Mandy Kirizoglou									
	1 and 2 Health a am 27 is		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Laurie M. Connor/Daughter 3126 Edgewood Drive, Pearland, TX 77584 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, S									
Baltimore,	t. Page rtment o rtant: If njury or		1 \(\text{Surial 2 \(\text{Cremation 3 \text{Removal from State} \) National Memorial Park \(\text{January 3, } \) \[\text{Value and Address of Facility} \] 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc									
B	permi Depa Impo any ii		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Occupancy (Final Occupancy).									
8760,	Physician /Medical Examiner physician and physician and physician and physician and physician are physician at the	ilcai Examiner										
P.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	Year								
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)	To the within 2 To the complet	M	29b. Signature and title of certifier Deputy 29c. License number 29d. Date signed (Month, Day, Y 12/30/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William PiJones, mp. 1995 America 21035									
	Sta Registr	_	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UIII Am Pi Jones MD 95 America 21035 31. Date filed (Month, Day, Year) 37 Registrar's Signature 12 N 0 3 2005 10 merica 2 10 35									

State of Maryland / Department of Health and Mental Hygiepe 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month 28°, 20°0°4 CHARLES PARKER COOK 6:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 14965 Fredrick Rd, Woodbine Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 8 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Hours XXM 2DF 96 Yrs. Director 212-22-0598 Maryland Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits rel', or Items 23e or 28a-f show Examiner must be notified at 1 Yes 2 No Director Woodbine Md Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14965 Fredrick Rd, 21797 U.S.A. death Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 € Yes, Give Year or Dates: W−W2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Importent: If item 27 is marked other then "naturel", or iter eny injury or other treumatic event, the Medical Exert 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 X Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 7th Grade Contractor Towing Inc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Charles G. Cook ပ Clara E. Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr Stuart Clarke (Nephew) 3421 Merle Drive, Windsor Mill, Md 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State Bushy Park Cem. 1/3/05 Cooksville, Md ¹ 4 □ Donation 5 □ Other (Specify) 2. Name and Address of Facility
Snowden Funeral Home P.A. 20050
246 N. Washington St, Rockville, Md
Approximate Interval Between Onset and Death Signature of Funeral Service Ligensee 22. Name and Address of Facility Snowden Funeral Home P.A. 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician a Atherosclevotic C ardiovuscular Visease years /Medical Due to (or as a consequence of): Examiner Abdomina 1ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner as the burial-transit The faw requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{Yes} \quad 2 \subseteq \text{No} \) Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown δ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Minknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Ves 2 No Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Matural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funerel C completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31473 Dec 29, 2004 10 ME mamo 30. Name and address of person who compled cause of death (Item 23a) (Type, Print) CONEWAY ElliGH City MD 21042 PATRICE A. TOYE, MD 456T HEMLOUR 31. Date filed (Month, Day, Year) JAN 0 3 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** DECEMBER 29, 2004 CHIDAKEL 11:28 A M PAULINE /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY tf Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JUNE 13, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthptace (State or Foreign Country) **Funeral** Hours Director 99 1905 WASHINGTON, DC 577-68-9836 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo WASHINGTON, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 4545 CONNECTICUT AVENUE, NW #835 20008 UNITED STATES Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No ģ Specify: 3 ₩ Widowed 4 Divorced WHITE "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if item 27 is marked oth any injury goether treumetic event once. 17. Father's Name (First, Middle, Last) Be PACH ROSE LEON LEWIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BURTON EDWIN CHIDAKEL, SON 11920 BAYSWATER ROAD, GAITHERSBURG, MD 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State CONG 12/31/2004 WASHINGTON, DC WASHINGTON HEBREW 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MEMORIAL PARK 21. Signature of Funeral Service Licensee DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. ottlement 1170 ROCKVILLE PIKE, ROCKVILLE, MD Ocnald (20852 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Stenosis /Medical Due to (or as a consequence of) Examiner pertensio Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of): The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Fetat death in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 Ninpatient 2 ER/Outpatient 3 DOA ٩ 1 Yes 2 □ No 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d, Desgribe how injury occurred Certification: After Injury 1 Natural 5 Pending ec, 5,2004 1 ☐ Yes 2 No 10 Un Known death. 2 Accident investigation the within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number City or Town, State) 4545 Connectic 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide AVE, NW, #835 10me Washington, 29a. Certifier 1 🗌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated: Medical 25 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier tucia 30. Name and address of person who completed cause of death (Item 23a), (Type, Print) oms 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

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	/Medic Examin		4a. Fecility Name (If not institution,	give street and numb	ber)		4b. City,	Town, or	Location o		30001130	7	ty of Death] 1 30 1	
			FREDERICK MEMOR		TAL		FRED	ERIC	CK			FRED	ERICK		
L	Funeral Director		5. Social Security Number 215–42–3498	5. Sex 7. 1 M 2 □ F	. Age (In yrs. i	last birthday) Yrs.	Months	1 Year Days	If Under 2 Hours	24 Hrs. 8	Date of Birth (Month, Day,	Ĭ945	9. Birthp Cour		reign
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exemplant must be notified at once.	by Funeral	11. Marital Status 1 Never Married Marrie 3 Widowed 4 Divorced	12. Was Deced Amed Force d 1\(\frac{1}{2} \) Yes 2 If Yes, Give Year or Date	es?		Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Specit , Puerto Ric	fy Yes or No- can, etc.)	Bla	ice - Americ ack, White, ify: Whi	etc.	
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Yes 2 Yes 3	20
Charles Clark, JR	
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and manner stated. 29b. Signature and title of certifier (f) 29c. License number 29d. Date signed (Month, Day, Year)	
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Thermy Yorks Degrees D28079 December 29, 2 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) Francis A. Higgs - Hours w 11700 BELTSUUS OR', BELTSUUS M.	
FRANCIOS A. HIGGS SHAMM, WO 11700 BELTSUUS OR , BELTSULLE IN	1
State Registrar DEC 3 0 2004	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Vear Month **Physician** 2004 21 Harvey Grinage Chase, Jr. December 6:30 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Central Cambridge Dorchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (Stete or Foreign Country) **Funeral** Days Months 1**K**IM 2□ F Director March 17,1923 Maryland 217-16-9272 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Department of Health and Mental Hygiena important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 Yes 2 No Director Marvland Dorchester Cambridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 902 21613 Central USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 Da Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐YNo Specify. Specify: Š 3 Widowed 4 Divorced Black Completed 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Minster Clergy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ္ Harvey Grinage Chase, Sr. Irene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Mary etta Chase / Wife</u> 902 Central Ave., P.O. Box 393, Cambridge, Md. 21613 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 12/27/04 Beulah, Maryland 22. Name and Address of Facility
Bennie Smith Funeral Home eture of Funeral rvice Licansee 524 Race Street, Cambridge, Maryland 21613 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shop, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical PEN nz Examiner Due to (or as a consequence of) Completed by Physician/Medical Examiner Hospital or Attanding Physician: The law requires that the death certificate ba executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown PIARKINSON IS M 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? CORON MAY MATTERY DISBASE 34 Nu 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No Medicai Certification: To this filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No daath. 2 ☐ Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20000 250 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) CALLUM 1009 Dutchmans Ln. Easton, Md.

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene [] [] [1 - State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 29, 2004 DECEMBER HAZEL M. CUSAAC 8:30A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1606 POLING AVENUE FORT fer 1 Year WASHINGTON If Under 24 Hrs. 8 PRINCE GEORGES 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 1 ☐ M 2 ☐ F Yrs. 30,1948 SOUTH CAROLINA Director 56 111-38-7587 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or items 23s or 28e-f show other traumatic event, the Madical Examinar must be notified at 1 XYes 2 No FORT WASHINGTON Directo MARYLAND PRINCE GEORGE'S 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20744 USA 1606 POLING AVENUE death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after at Hygiene." neturel', or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service Postal Clerk 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fi and Mental H Henzley Williams Lillie Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Is 1606 Poling Avenue Fort Washington, MD William R. Cusaac/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite eny injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Cem. 1-6-2005 Florence, S.C. ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. muscoe pour Mullely 4308 SUITLAND ROAD SUITLAND, MD 20746 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC NONSMALL CELL LUNG CANCER $3\frac{1}{2}$ years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 the à signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4x Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an XXNo 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one examiner' Other: 4 Nursing Home XX Residence 6 Other (Specify) 2 XXYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA his funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending Injury XXNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after deatl Director: 6 Could not be determined 3 Suicide 28e. Płace of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 🗶 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1-3-2005 DC10200 MAN

20 State

31. Date filed (Month, Day, Year)

Dennis Priebat, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

110 Irving ST., NW

Washington DC

20010

			1 - For State Registrar	State of Marylan		artment rtificate			and M		giene ()	04	428	23
	Physici	an	Decedent's Name (First, Middle, Last)							2. Date of Dea Month	Day	Year	3. Time of	Death
	/Medic		Richard Roger Car							Decembe	-	2004	10:26	A M
	Examin	er	4a. Facility Name (If not institution, give st	·		4b. City, To			of Death			nty of Death		
			Anne ArundelMedica 5. Social Security Number 6. Sex	7. Age (In yrs. i	last hirthday)	Anna If Under 1		If Under :	24 Hrs.	8. Date of Birt	h	Arun		V. Foreign
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	with a or	Funeral Director		Tana		10f. Zip C	2071	5			10g. Citizen o		intry?	
	ns 23	era	2603 Kinderbrook	Lane 2. Was Decedent Ever in U.	S. 13.				gin? (Spe	cify Yes or No-		A. ace - Ameri	ican Indian.	
ထ	or Iter		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No					, Puèrto i	cify Yes or No- Rican, etc.)		lack, White,	, etc.	
ğ	ral', c	d by	3 ☐ Widowed 4 🖟 Divorced	If Yes, Give 70. Year or Dates:		1 □ Yes 2]	XI No	Specify:			Spec	cify: Bla	ack	
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12	withir ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		ouse 1					Cloth:	ing Re	etail	
д 5	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Marical Examinational be multified at	C	17. Father's Name (First, Middle, Last)		warer	ioube i	1011			(First, Middle,				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It is Modical Examinational be notified at ODGs.	To Be	Fred Hunt					Ge	rtru	de Care	y			
ary	and N	_	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (S	Street a	ind Numbe	r or Rura	l Route Numbe	r, City or Tow	n, State, Zij	p Code)	
Σ,	and and a palith n 27 in		Rev. Harry Patterso					ook La		Bowie,		20715		
Baltimore,	ges 1 t of H If iten		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	moval from State	lace of Dispo emetery, crer	natory or other	er place	· 1		ate	20c. Location	n - City or T	own, State	
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687	at Se	edicai	d.											
Вох	death certifica attending ph d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	ic. If yes, outcome of pregna 1□Live birth 2□Fetal		Ectopic preg					23d. D	Date of deliv	rery	
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>	ysician: nis certifica director, p	To B	examiner?	ospital: 1 🕱 Inpatient 2 🗆	ER/Outpatien	t 3 DOA	Othe			(Check only or ne 5 ☐ Resid		ther (Speci	fv)	
10	Attending Physician: r death. sctor: After this certific by the funeral director, I		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		2. Injury Work			8d. Describe h			.77	
Sior	itendin death. tor: Af the fur	atlc	1 Natural 5 Pending 2 Accident investigation	(,,	М		res 2□N	No					
Division of Vital Records,	after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str /)	eet, factory, o	office		2	28f. Location (S City or Tow	treet and Nun n, State)	nber or Rura	al Route Numi	ber,
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			nou	dBak to			46	052			Decemb	er 30	, 2004	
	(2)		30. Name and address of person who con	npleted cause of death (Item	23a) (Type,	Print) Da	1461	14.	Λ.	apolis,				
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			1 - For State Registrer		State of	Marylar	nd / Depa		of Healtl	h and N	Mental Hy	/giene	3.5.6.4		
	Physicia	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year											3. Time of Death	
	/Medic Examin Funeral		Ann R. Cuneo 4a. Facility Name (If not institution, give street and number)						Dec. 18 4b. City, Town, or Location of Death				004 County of Dea	8:00 A ^M	
		er	Manor Care Chevy Chase										ntgome		
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. D.								8. Date of Bi	Oate of Birth Month, Day, Year) 9. Birthplace (State or Foreign Country)			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "netural", or Itams 23e or 28e-f show any injury or other traumatic svent, the Medical Examiner must be notified at once.		193.01.8344	1 L N	1 24□ F	8	7 Yrs.	I WOTHING	ays Hour	17111.	Sept.2			nnsylvania	
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			5000 Rockmere Court 20816 USA												
			11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?					13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					4. Race - Am Black, Whi		
36			44	1 Never Married 2 Married 1 Yes 2 No If Yes, Give					No Spec		Specify: White				
Ö		q pe	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupat						oquestion	ation 16b. Kind				d of Business/Industry	
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<u>yla</u>		길	George Cuneo Kunigunda Yeager												
Maryland 21215-0036			19a. Informant's Name/Relation Mary Kathleen			.ce					hesda,		Town, State, 20816	Zip Code)	
<u>6</u>			20a. Method of Disposition		·	20b. I	Place of Dispo	osition (Name o	of		Date	20c. Loc	ation - City or	Town, State	
OE.			1 X Rurial 2 Cremation 3 Removal from State cemetery, crematory or other place)							Dec.28	3,2004	,2004 Silver Spring, MD			
Baltimore,			21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Signature of Funeral Service Licensee 24. Signature of Funeral Service Licensee 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 21. Signature of Funeral Service Licensee												
w.	20 E 9 9		W. Athy / Leville 5130 Wisconsin Ave. N.W., WDC 20016												
	Physician: The law requires that the death certificate be executed X X X Wherever, this certificate has been signed by the attending physician and a director, page 2 should be detached for use as the burial-transit		23a. Part1. Enter the disease of complications that cave ded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on exist line. Approximate Interval Between Onset and Death												
		by Physician/Medicai Examiner	Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pneumonia 6 weeks												
						as a consec	saur manus								
			Sequentially list conditions, if any, leading to immediate Quasa. Enter Underlying b. Chronic Tysphacia Due to (or as a consequence of):										6 mths		
			Cause (Disease or injury that initiated events c.											1 year	
760,			resulting in death) Last Due to (or as a consequence of :								20			3 years	
∞ -				d.	Coronary And Cerebrovascular Disease									J years	
9 X0			IF FEMALE: 23c If was outcome of premancy										2d Data of da	at a fidelities	
Bo			23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Ectopic pregnancy 1 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)									23d. Date of delivery Month Day Year			
o.			1 Yes 21 No 9 Unknown 9 Unknown												
ď.			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did	id tobacco use contribute to the cause of death?			
ğ		edt							1]Yes 2□No 3□Probably 4X5Unknown		
Records,		pie										24a. Was an autopsy autopsy 24b. Were autopsy findings available prior to completion of cause of			
		Completed										performed? death? 1 ☐ Yes 2至 No 1 ☐ Yes 2 ☐ No			
Viita		Be	25. Was case referred to medical examiner? 1 Yes 2 3-40 Hospital:												
Division of		: To	1 Impatient 2 DDA 4 Ministry name 5 Hestaence 6 Dottner (Specify)											ecify)	
O	To the Hospital or Attending F within 24 hours after death. To the Funerel Diractor: After completely filled in by the funer	Medical Certification:	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Dest 1XXNatural 5 □ Pending (Month, Day Year) 2 □ Accident investigation 28b. Time of 28c. Injury at 28d. Dest Nort? 4 1 □ Yes 2 □ No												
VISI			3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street									n (Street and Number or Rural Route Number, Town, State)			
			4 Homicide building, etc. (Specify) City or Town, State)										<u></u>		
			29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
												e signed (Month, Day, Year)			
,			Jane Hostar 12 Do4 179 12									12	2/28/100		
	20		30. Name and address of person	on who com			m 23a) (Type,	Print)		/		/		107	
				Foster				in Ave.	, Chev	vy Cha	se, MD	208	15		
	Sta Registr														

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 30, 2004 **Physician** GASKIN DOUGLAS 3:08A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL PRINCE GEORGES CLINTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** .Sex XXIM 2□ F Months Yrs. Director 247 70 5731 26, 1943 SOUTH CAROLINA Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City, Town or Location 10d, Inside City Limits rel', or items 23e or 28e-f show Examiner must be notified at XX Yes 2 No Director MARYLAND PRINCE GEORGES SUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3202 LASSIE AVENUE 20746 Completed by Funeral UNITED STATES Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

ont: If item 27 is marked other then "neturel", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: BLACK 3 Widowed 4 Divorced treumatic event, the idealisal 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12TH TRUCK DRIVER SELF-EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GASKIN DOUGLAS, SR. ELEASE McCALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY DOUGLAS / WIFE 3202 LASSIE AVENUE SUITLAND, MD 20746 other 20a. Method of Disposition

Method of Disposition 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Importent: If it any injury or o ^¹ 4 □ Donation 5 □ Other (Specify) FT. LINCOLN CEMETERY | 01/04/2005 BRENTWOOD, MD 21. Signature of Funeral Service Licensee MARSHALL S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20/46 23a. Part1. Pliter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock. I heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician andiomyspaths disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner arle oronary Sequentially list conditions, y leading to recall cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? g 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfor certificate 2∏ No 1 Yes 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Impatient Certification: To 2 ER/Outpatient 3 DOA this Manner of Death 28b. Time of 28c. injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1-Natural 5 Pending 1 Tes 2 No 2 Accident investigation filled in by the Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier etrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel the within 2 and title of tertifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) JUMUU MD D0053813 04 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name an Dumais 7503 Surratts Road 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 4 2005 Registrar

			1 - For State Registrar		Marylar	-	artment of H rtificate of I		nd Mental H	Reg. No		42826
	Physic	an	1. Decedent's Name (First, Middle Elizabeth		vis				2. Date of I		5, 2004	3. Time of Death
П	/Medi	cal	4a. Facility Name (If not institution				4b. City, Town, or	Longtion of			County of Death	5:57p⁄m
	Examir	ner	Prince George'		91)				Death			maa l a
	Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs.	last birthday)	Cheverly	If Under 24		Birth	ince Geo	lace (State or Foreign
	Director		57884-8383	1□M 2MF	58	Yrs.	Months Days	Hours	Min. April	1, Year	946 Sier	ra, Africa
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation				1	0d. Inside City Limits
	Maryl f sho	ō	DC			shingt						1√2 Yes 2 □ No
	r 28a	irec	10e. Street and Number	-			10f. Zip Code			10g. Cit	izen of What Cour	ntry?
	th witi	Funeral Director	901 1st St.	N.W.			20	0001		Un	ited Sta	tes
	tems	ner	11. Marital Status	12. Was Deceder Armed Force	s?	l.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin, Mexican,	n? (Specify Yes or I Puerto Rican, etc.)	No-	14. Race - Americ Black, White,	
36	or l	by Fi	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 【XDivorced	ned 1 ☐ Yes 210 If Yes, Give Year or Date:	No.		1 ☐ Yes 2 XX No	Specify:			Coorife	lack
8	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show he Medical Examiner must be notified at	ed t	15. Decedent	t's Education	s.	16a. Dece	dent's Usual Occupa	ation		16b. K	ind of Business/Inc	
215	hin 72	Completed	(Specify only highes Elementary/Secondary (0-12)	st grade completed) College (1-4c	or 5+)	(Give	kind of work done of DO NOT use retired	<i>furi</i> ng most o	of working			,
2	ed wit	Соп		4		Но	tel Manag	er		Н	lotel	
n	be file	Be	17. Father's Name (First, Middle, I						s Name (First, Midd			
Maryland 21215-0036	d Men narke	2	Charles Davis			105 14-35			ttaneu Ma			
a Z	d 2 sl th an t7 is r traur	1 3	19a. Informant's Name/Relationsl Claude Tompk						or Rural Route Num	-		
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, The Medical Examiner must be notified at		20a. Method of Disposition	1115 / 3011	20b. F		sition (Name of natory or other place		N.E. Wash		n DC 200 ocation - City or To	
E O			1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St				natory or other piaci incoln Ce	I	1-4-05	Bro	ntwwon,M	D
altimore,	permit. Pages 1 a Department of Hea Important: If item any injury or othe		21. Signature of Funeral Service I						pe Funera			D
<u> </u>	88 28		Will of -	targe TD	1005				E Washing			
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each	iline. e Cor	onary	er the mode of dying Syndrome	g, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
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.O. Box 6	the death certific. by the attending pi ached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	al death 3	Ectopic pregnancy Other (specify)				23d. Date of delive Month	ory Day Year
rds, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant condition	ons contributing to death	but not res	sulting in the u	nderlying cause give	on in Part I.			ise contribute to th	e cause of death?
Vital Records,		Completed							24a. Wa aut per	opsy formed?	prior to cor death?	osy findings available inpletion of cause of
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hacrital.					f Death (Check only	one)		
0	Physi this o	2	1 ☐ Yes 2 XNo 27. Manner of Death	Hospital: 1 Inpa	777	ER/Outpatien		4 Nurs	ing Home 5 Re			7)
5	ding l h. After funer	lon	1 XNatural 5 Pending	9	Day Year)	28b. Time of Injury	Work	at ? ′es 2 ⊡No	28d. Describe	now injur	y occurred	
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification and the funeral director the funeral director.	Certification;	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	not be 28e. Place of I	Injury - At he etc. <i>(Specit</i>	ome, farm, str y)	eet, factory, office	03 2 110	28f. Location	(Street an own, State	d Number or Rura.)	l Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical (29a. Certifier 1 Certifying (Check only one) 1 Medical 8	g Physician: To the bes Exeminer: On the basis and manner	of examina	wledge, death	n occurred at the tim restigation, in my op	e, date and pinion, death	place, and due to the occurred at the time	e cause(s) e, date and	and manner as st place, and due to	ated. the cause(s)
	To t withi To t	Σ	29b. Signature and title of certifier				29c. License	number		29d. Dat	e signed (Month, L	Day, Year)
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12			30. N and address of person v	·		П (Туре,						1
			OPanell Cumb 31. Date filed (Month, Day, Year)					e,Chev	verly,MD_			
	Sta Registr		JAN 0 3 2	005 Between	کر ک	sture Spe	le					

			1 _ For State	State	of Maryla	nd / Depa	artment rtificate	of He	ealth and M Death				42827
	₩		1. Decedent's Name (First, Middle	, Last)		007	inoato	, 0, 2	Joan	2. Date of De			3. Time of Death
	Physicia /Medic		Ethel Padgett D	urham						Decemb	er 2		3:05 p M
	Examin	er	4a. Facility Name (If not institution	-	ımber)		4b. City, T	own, or	Location of Death		40	County of Death	
			2445 Lyttonsvill	Le Road	7 Ago (In um	s. last birthday)	Silv If Under 1		Spring If Under 24 Hrs.	8. Date of Bir		ontgomer	y
	Funeral Director		5. Social Security Number 577.01.7135	1 M 2K F) 4 Yrs.	Months		Hours Min.	Jan. 28	ıy, Year)		place (State or Foreign ntry) h Carolina
Sep.	3-		Usual Residence of Decedent							Jan. 20	171		
aryłan	show	_	10a. State 10b. County MD Montgo	merv	1	City, Town or Lo Silver S							10d. Inside City Limits 1 → Yes 2 □ No
the M	28a-f	ecto	10e. Street and Number				10f. Zip (10a. Cit	izen of What Cou	
with r	3e or	II Di	2445 Lyttonsvil	le Road			,	910			USA		,
fter death	r Items 2 licer mu	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Armed F ied 1 ☐ Yes	2 X No				spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Ameri Black, White,	
ours a	ral', o	d by	3 ☐ Widowed 4 € Divorced	If Yes, G Year or (ive Dates:		1 Yes 2		Specify:			Specify: Wh:	
72 h	natu	letec	15. Decedent (Specify only highes)	(Give	dent's Usual kind of work DO NOT use	k done di	uring most of work	ing	16b. K	ind of Business/Ir	ndustry
withir	than than	Completed	Elementary/Secondary (0-12)	College	1-4or 5+)		lnen B				Dep	partment	Store
	other other vent,	BeC	17. Father's Name (First, Middle,	Last)					18. Mother's Name			Sumame)	
y id	Menta arked atic e	To E	Robert T. Padge						Ethel F				
and 2 sho	alth and 27 Is m er traum		19a. Informant's Name/Relations Barbara Poston		er	19b. Mailir 250 M	ng Address Iallar	(Street a d La	nd Number or Run ake Drive	, Early	er, City o	or Town, State, Zij Lle, VA	22936
Dermit. Pages 1 a	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show important: If item 27 is marked other than "natural resolution at once.		20a. Method of Disposition 1		State Ga	Place of Dispo cemetery, crer ston Me metery	sition (Naminatory of ott moria.	e of her place 1	9)	1,2004		cation - City or T	
permit.	Departr Importa any inji		21. Signature of Funeral Service	Licensee Bc	eggs-				^{s of Facility} Jose nsin Ave	-			nc.
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anding P	ath. or: After thi ne funeral o	ertification:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	gation	of Injury oth, Day Year)	28b. Time o Injury	M 28	e, Injury Work	at ? ∕es 2 □ No	28d. Describe	how inju	ry occurred	
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ne Hospi	within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director. It	edical	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To th Examiner: On the and ma	e best of my k basis of exami nner stated.	nowledge, deat nation and/or in	h occurred a vestigation,	at the tim in my op	e, date and place, pinion, death occur	and due to the red at the time,	cause(s date and) and manner as s d place, and due t	stated. o the cause(s)
		ž	29b. Signature and title of certifie						number			te signed (Month,	•
ĺ	,0		Honory	Tym				2555	3	-	Dece	mber 23,	2004
			30. Name and address of perso Phuong D. Trin	h, M.D.,	8603	Fenton		230,	Silver	Spring,	MD	20910	
	Sta Registi		31. Date filed (Month, Day, Year) DEC 3 0		Registrar's Sig	, D	Spo	reks	/				

			Please	State of Ma				•	•	
			for State	State of Ma		artment of t ertificate of	Health and M			42828
			Registrar 1. Decedent's Name (First, Middle, Li	ast)		Tillicate of	Dealli	2. Date of Death	. No.	3. Time of Death
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	/Medic		4a. Facility Name (If not institution, gi		70		or Location of Death	December	28 2004 4c. County of Death	
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	Funeral				Vn yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		place (State or Foreign
Н	Director		219 23 1836	1□M 2 ∑ F	15 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y March 9,	1989 Mar	yland
	P.		Usual Residence of Decedent		10.00					
	shov	<u>_</u>	10a. State 10b. County		10c. City, Town or L.					10d. Inside City Limits 1 ☐ Yes 2 No
	Se-f	ecto	MD Howard		Highla					
	with the	급	10e. Street and Number	Dood		10f. Zip Code 207	777	109	. Citizen of What Cou	
	within 72 hours after death with the Maryland ane. than "natural", or Itama 23a or 28e-f show he Medisal Enaminer must be notified at	Completed by Funeral Director	7429 Mink Hollow	12. Was Decedent 8	iver in U.S. 13			acifu Vas or No-	United St	
	ter d	5	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X N		If Yes, specify Cub	Hispanic Origin? (Spe pan, Mexican, Puerto	Rican, etc.)	Black, White,	
036	urs a	β	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2☑ No	Specify:		Specify: Wi	nite
21215-0036	2 ho	ted	15. Decedent's E (Specify only highest gi	Education	16a. Dece	edent's Usual Occu	pation during most of worki	16	b. Kind of Business/Ir	
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21	ed wi	S	9		Stı	ıdent			N/A	
nd	d oth	Be	17. Father's Name (First, Middle, Las					(First, Middle, Ma.	iden Sumame)	
yla	Men	၉	Alexander D. Dunk				Martha A			
Maryland	12 sh h and 7 le m traum		19a. Informant's Name/Relationship Alexander D. Dunk				t and Number or Rura . lo w Road I		ity or Town, State, Zip	Code)
e,	1 and Healt em 2 ther	12	20a, Method of Disposition	bal/raulei	20b. Place of Disp				c. Location - City or T	own State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 le marked other than "natural", or Itama 23a or 28e-f show apprintury or other traumatic event, the Medical Examiner must be notified at ance.		1 ☐ Burial 2 🛣 Cremation 3 l		Metro Ci	matory or other pla			atonsville	
臣	it. P		4 ☐ Donation 5 ☐ Other (Spec21. Signature of Funeral Service Lice				1			
Ba	Department of the series of th		\$ 50.0 C20	- (1) (1)					cott City,	ly FH Inc.
	- J		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that gused						Approximate
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f V	Physician: this certificaral director, (To E	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/Outpatie	nt 3 DOA	bos		e 6 Other (Special	y)
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Certification;	(Check only one)	hysicien: To the best of miner: On the basis of and manner sta	examination and/or in	nvestigation, in my	opinion, death occurre	ed at the time, date	and place, and due to	the cause(s)
	othio othio omple	Me	29b. Signature and title of certifier			29c. Licens	se number	29d.	Date signed (Month,	Day, Year)
	- s - ō		Krotinan	elso	Mp	RES	5-000	Da	rember 78	2014
100	7		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type	, Print)		P	10740 20	1
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	Sta		31. Date filed (Month, Day, Year)	32. Pogistra	r's Signature	Carlot .		,	,	

ysici	an	1. Decedent's Name (First, Middle, Last	,						M	ate of Death onth	Day	Year	3. Time of Dea
ledio		Mary E. Dorri 4a. Fecility Name (If not institution, give				4b City T	OWD OF	Location of		CEMBER	4c. Count	Zooy	12:04
amin	er	Calvert Manor	street and numbery			Risi			Death		Cec		
eral		5. Social Security Number 6. Sec	-	e (In yrs. la	st birthday)	If Under 1	Year	If Under 2	4 Hrs. 8. Da	te of Birth			place (State or Foi
tor		022-10-1020]M 3 €7 F	81	Yrs.	Months	Days	Hours	Jul	y 8,	1923	Mas	
		Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Lo	cation							104 1-14-01-11
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	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	. 13.)				in? (Specify Y Puerto Rican,				can Indian,
	₫	1 Never Married 2 Married	Armed Forces?	No					Puerto Rican,	etc.)	Bla	ck, White,	etc.
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		Albert J. Dorris	g/Hushar	n d					Elkto			_	Code)
r other traumatic e	1	20a. Method of Disposition	b) IIabbai	20b, Pla	ce of Dispos	sition (Name	of		Date	_	Dc. Location -	921 City or To	own. State
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ODCE.		21. Signature of Funeral Service License	99	R.C	· Ce	meter Name and	dress	of Facility	2005		CHEL	ту г	ITTT, MD
on o		I Eduard Mr	Korn		A	ndrew	G.	Gee	Fune	ral 1	Home		
3		23a. Part1. Enter the disease, or compliant shock or heart failure. List only or	ications that caused	the death.	Do not ente	59 E.	Ma of dying,	in S	ardiac or respi	1ktor ratory arres	n, MD	21	921 Approximate
ian		Immediate Cause (Final	io cause on each iii	10.			4						Interval Between Onset and Death
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	lan	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome	2 Fetal d	eath 3 🗌	Ectopic preg					23d. Dat Mo	e of delive	ory Day Year
	hysician/Me	1 ☐ Yes ②⊠No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dear	tn 5 🗆	Other (spec	ty)				14101	· +48 1	-uy ital
	۵.	Part II. Dther significant conditions con	tributing to death by	ut not resulti	ng in the un	deriving caus	Se diven	in Part I	23	e. Did toba	cco use contr	nhute to th	e cause of death?
	9		ū				9. , o.,			1 🗆 Yes	27		ably 4 □Unkno
	Completed												
	E .								24	 Was an autopsy performe 	_ P	Vere autor prior to cor leath?	psy findings availating of cause of
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	Certification	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	rv - At home	e, farm, stre					ation (Stree	at and Number	er or Rura	l Route Number,
	ert	4 Homicide determined	building, etc	. (Specity)	,	,, -			City	or Town, S	State)	J. 0. 110121	TIDUIO INDINDIO,
	O 1	29a. Certifier Certifying Phys	ician: To the best o	f my knowle	edge, death	occurred at t	he time,	, date and p	place, and due	to the caus	se(s) and mai	nner as sta	ated
f	CC	one) 2 Medical Examin	ier: On the basis of and manner sta	examination	and/or invi	estigation, in	my opin	nion, death	occurred at th	e time, date	and place, a	ind due to	the cause(s)
	edical	Dire)				20- 1	cense r	numbor		7 004	Date of a		
	Medical	29b. Signature and this of certifier				290. L	C01130 1	шпрег		290.	. Date signed	(Month, L	Day, Year)
			\leftarrow				58	_			. Date signed TEMBEN		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42830 Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 90 **Physician** DECEMBER 22 2004 JAMES LEE EWING 1850 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S 1800-EE8 CORSICA HILLS-GENESIS ELDERCARE CENTREVILLE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) SEPT. 11 1933 9. Birthplace (State or Foreign Funeral Days 10XM 2□F Director 214-32-1469 MARYLAND Usual Residence of Decedent with the Maryland ahow 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23a or 28a-f aho XXYes 2 No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 CRABAPPLE COURT 21601 USA 12. Was Decedent Ever in U.S. Armed Forces?
KXXYes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 ☐ Widowed 4 Ĭ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICIAN CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MILTON GREENLEY EWING DOROTHY ANNA DULIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES A. SINCLAIR/NIECE 10819 HINERS LANE EASTON, MD 21601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 12-29-2004 HURLOCK, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 亚 M. E. Dewnain FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 41-6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic obstacting planning Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 68760 lan/Medical by the ettending preched for use as Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown d be dete O OT Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, ź 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 0 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an or, page 2 s r this certificete h ral director, page 1 Yes 2) 200 Vital Mark or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Sursing Home 5 Residence 6 Other (Specify) P 1 Yes 20 No o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred <u></u> b⊟Natural 2 ☐ Accident 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No I Director: / Divisi 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, Jeath December at the time, Jate and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature)and le/of certifier 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) Charley, MD 21619 2108 Drive D. Donah SUR 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

				State of Maryland / Department of Health and N 1- State Registrar State of Maryland / Department of Health and N Certificate of Death		giene Reg. No. 0 () 4	42831
		Physici /Medic		1. Decedent's Name (First, Middle, Last) ChitANCE C. English	2. Date of Dea	Day	Year	3. Time of Death
		Examin		4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL 4b. City, Town, or Location of Death BETHESDA		4c. County	of Death	ERY
		Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth MAY 17	⁷ 1947	9. Birthp Cour	lace (State or Foreign try) MD
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		death with the Maryland ms 23e or 28e-f show	Il Director	10e. Street and Number 19136 HEMPSTONE AVE. 10f. Zip Code 20837		10g. Citizen of	What Cour	ntry?
	920	be filed within 72 hours after death with the Maryla hal Hygiene. Id other then "neturel", or Items 23e or 28e-f show event, the Madical Examinational Local Miled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Eyer in U.S. Armed Forces? 1 Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes, Sive Year or Dates:	ecify Yes or No- Rican, etc.)	Bla	ce - Americ ck, White, v: WH]	etc.
	21215-0036	be filed within 72 hours after tal Hygiene. d other then "neturel", or Ite event, the Madical Examina.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CAFETERIA MANAGER		16b. Kind of B MONTGO SCHOOI	MER	CO.
	rland (and 2 should be filed withir ealth and Mental Hygiene. n 27 is marked other then ter treumatic event, the M	To Be C	17. Father's Name (First, Middle, Last) DR. WILLIAM DWIGHT CURTIS 18. Mother's Nam ELIZAE	e (First, Middle, BETH PO		пе)	
AM	, Mary	s 1 and 2 should f Health and Mer item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Type, Print) FRED EMORY / SPOUSE 19b. Mailing Address (Street and Number or Rur 19136 HEMPSTONE AV	ZE., PO	r, City or Town, OLESV]	State, Zip	Code) MD 20837
15 A	Baltimore, Maryland	Pages 1 nent of Hi ent: If iter ary or oth		comptent cramatons or other place)		20c. Location FREDER	-	wn, State
160	Balt	permit. Departr Importe eny inji		21. Signature of Furnital Service Licensee 22. Name and Address of Facility HILTON FUNERAL H. P.O. BOX 86, BAR	HOME RNESVIL	LE, MI	20	1838
1		Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a				Approximate Interval Between Onset and Death
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AN	rds, P.	w requires that the by been signed by should be detac	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol		ribute to th	e cause of death?
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F		To the Hospitel within 24 hours a To the Funerel C completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cared at the time, da	ause(s) and ma ate and place,	nner as stand due to	ated. the cause(s)
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				721673		Dec :	11,2	Yea
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RMPH Boccia w. J. 6420 Roccia Gr.	Penses	m h	ヘカ	
		Sta Registr		31. Date filed (Month, PAN'ell) 3 2005 32. Raistrar's Signature				

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	. For	State of Maryla	nd / Department of	Health and Mer	ntal Hygiene	3001 1000	
	1 = State Registrar		Certificate of	Death	Reg. No	2004 4283	2
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/Medica Examine			4b. City, Town,	or Location of Death		. County of Death	
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Funeral		Sex 7. Age (In yrs	. last birthday) If Under 1 Year		Date of Birth (Month, Day, Year)		eign
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2	Usual Residence of Decedent				41-27	120 110	
Maryland -1 show	10a. State 10b. County		ity, Town or Location			10d. Inside City Lin	
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with the	10e. Street and Number	2	10f. Zip Code		10g. Cit	tizen of What Country?	
) = E3 = 1	P.O. BOX 20	18		473		USA	
difference or Items	11. Marital Status	12. Was Decedent Ever in I	U.S. 13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Specify ban, Mexican, Puerto Rica	Yes or No-	 Race - American Indian, Black, White, etc. 	
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Bal Bal Bal Bal Bal Bal Bal Bal Bal Bal	21. Signature of Funeral Service Lice	nsee 7/	Henry Fo	uneral Home	e, P. A.	e, MD. 21613	
	sanelle (, stewy	510 Wash	rington St. C	ambridg	e, MD. 21613	
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The atte ha					performed?	death? 1 ☐ Yes 2 ☐ No	71
Vital Rec siclen: The lav siclen: The lav siclor, page 2	25. Was case referred to medical			26. Place of Death (Ch			
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the Hospi in 24 hou the Funer pletely fill	(Check only 2 Medical Exa	miner: On the basis of examination	ation and/or investigation, in my	opinion, death occurred at	the time, date and	place, and due to the cause(s)	
Division of Vital Re To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	29b. Signaturetand title of certifier	A	29c. Licens	se number	29d. Date	e signed (Month, Day, Year)	
	1 // ->	N DO	DY	18064	16	-178/04	
	30. Name and address of person who	complete cause f death (Ite					
			utchmans Lane I	Pagton W-		22	
State			ature Larie 1	caston, Mary	Tand 516()1	
Registrar	DEC 29	2004	H. Cooch's				

State of Maryland / Department of Health and Mental Hygiene 42833 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** FELDMAN ZENA 9:45AM DECEMBER 25, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY HEBREW HOME OF GREATER WASHINGTON ROCKVILLE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth

JULY 30, 1907 Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 😿 F 97 567-21-5990 Director CHINA Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location a 23a or 28a-f show 1 XYes 2 ☐ No ROCKVILLE MONTGOMERY Directo MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20852 UNITED STATES OF AMERICA 6121 MONTROSE ROAD Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ᠫ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme any injury or other traumatic event, Ite Wed Fall Examination. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SARAH LEMPERT JOSEPH FELDMAN 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7531 SEBAGO ROAD, BETHESDA, MD 20817 REVA JOLOVITZ - DAUGHTER 20c. Location - City or 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 Cremation 3 Xemoval from State SALEM MEMORIAL GARDEN 01/03/05 * 4 ☐ Donation 5 ☐ Other (Specify) CALIFORNIA 22. Name and Address of Facility PANZANSKY GOLDBERGE MEMORK OLLCHAPED , 20852 23a. Paint. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Lover Gastointestinal disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician ician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown signed by t Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 Yes 2 0 No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Wells 55258 ecenter 25 2004 30. Name and agdress of person who completed cause of death (Item 23a) (Type, Print) WONTYOF LUKULLLE J0825 W1/43. agistrar's Signature 31. Date filed (Month, Day, Year) 32. State JAN 0 3 2005 Registrar

ORIGINAL

			1 For State		Maryland /		artmen				lental Hy	•	200	1.	1. 2	0.21
	0		Registrar AMFND#19bp=YTNF 1. Decedent's Name (First, Middle, Last)		MW, McCo		uncare	OIL	Jeaur		2. Date of De			1-3	3. Time	of Death
	Physicia /Medic		BELLE		FOSTER						Month DECEME	Da BER 2	y Ye	ear 04	9:10	
	Examin		4a. Facility Name (If not institution, give	street and numbe	ar)		4b. City,	Town, or	Location of	of Death			. County of E			
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п	Funeral Director		5. Social Security Number 6. Security Number 165-40-0656	x □M 2⊋F 7.7	Age (In yrs. last b 92	oirthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da MAR 2,	rth ay, Year)	9.	Birthpla Count	ace (State try) SYLVA	or Foreign
			Usual Residence of Decedent	Λ	92		<u> </u>				MAR Z,	191	. Z P	LNN	SYLVA	MLA
	ryland thow	_	10a. State 10b. County		10c. City, To	wn or Lo	cation							10	d. Inside	City Limits
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	with the	Dire	10e. Street and Number	!!			10f. Zip						izen of Wha		-	
	eath is 23	erai	199 ROLLINS AVENUE	1, #726 12. Was Deceder	nt Ever in U.S.	13	Was Deced	208		ain? (Sac	offy Vas or No		ED ST.			
മ	or iten	Funeral Director	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 🐼	s?						cify Yes or No Rican, etc.)		Black, V			
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f show ite Marical Exerciper must be notified at	1 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	s:		1∐ Yes 2	X No	Specify:				Specify:	WI	HITE	
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12	withir ene. than	dmo	Elementary/Secondary (0-12)	College (1-4o	or 5+)		HOMEM						OWN H	OME		
	Hygid Other ent, II	Be Co	17. Father's Name (First, Middle, Last)							r's Name	(First, Middle	, Maiden		JIII		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumatic event, the Marical Exercities must be rotified at once.	To B	BENJAMIN	WEINSTE	EIN					ANNA	1	(UN	ASCER'	[AI	NABLE)
lary	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (Ty	pe, Print)							l Route Numb	er, City c	r Town, Stat	е, <i>Zip</i> (Code)	
	l and fealth m 27 her tr		EILA AMDUR, DAUGH	TER			BAUE		IVE,		ROCKVI			2085		
Jor	Pages 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		(0)	ery, crer	natory or ot	her place	· 1		ate		cation - City			
Baltimore,	artmer ortent injury		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License		JUDEA						The state of the s		EY, MA			
Ba	permit. Departr Importe any inju		Domald C.	Otan	Tames of	DA 11	NZANS 70 RO	KY-G CKVT	OLDBI	ERG M	MEMORIA ROCKV	L CH	APELS	, IN 208		
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caus									, rid	17.5	Approxima Interval Be	ate
Į,	Physician :		Immediate Cause (Final disease or condition		MYELOGE										Onset and	d Death
	/Medical Examiner		resulting in death)	A	as a consequence		delon								/ LI LICO	
		_	Sequentially list conditions, if any, leading to immediate	Due to /or o	20.0.0000000000000000000000000000000000	- af\-								_		
	nsit	nine	Cause (Disease or injury	Due to (or a	as a consequence	or):								1		
o,	execu in and ial-tra	Examiner	that initiated events resulting in death) Last		is a consequence	of):								-		
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39	artifica ing ph e as ti	Med	IF FEMALE:		. 8-11	-						- 1				
Вох	death certificate at the second of the secon	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal deat		Ectopic pre					1	23d. Date of Month		-	Year
o	that the de ed by the a detached	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnant 9⊟ Unknown	at time of death	5∟	Other (spe	icity)							,	
۵.	signed by d be detac	by Ph	Part II. Other significant conditions con	tributing to death	but not resulting	in the ur	nderlying ca	use givei	n in Part I.		23e. Did t	obacco u	se contribute	a to the	cause of	death?
rds,	w requires been sig should be										10	Yes 2	XNo 3□	Proba	bly 4 🗆	Unknown
Vital Record	e law requ has been je 2 shouli	Completed									24a. Was		24b. Were			
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6	hys his	- To	1 ☐ Yes 2X No 27. Manner of Death		tient 2 ER/O			_	4 🗀 1401		ne 5 ☐ Resid			pecify)	HOSP	ICE
O	ding Ph h. After th funeral	tion	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D	Day Year)	Time of Injury	M 28	lc. Injury Work?	at ? es 2 □ N		8d. Describe I	now injur	y occurred			
Division of	or Attending after death. Director: After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of I	njury - At home, f	arm, stre					8f. Location (S			Rural	Route Nur	nber,
á	s after el Dire	Certification:	4 Homicide determined	building, e	etc. (<i>Specify</i>)						City or Tov	vn, State,)			
	Hospi 4 hour Funer tely fill	edical	29a. Certifier (Check only one) X Certifying Phys 2 Medical Examir	sician: To the bes ner: On the basis and manner s	of examination at	e, death	occurred a restigation, i	t the time in my opi	e, date and nion, deat	d place, a	nd due to the d at the time,	cause(s) date and	and manner place, and c	as stat	ted. he cause(s)
	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certifier	and mailler s	Juliou.		29c.	License	number			29d. Date	e signed (Mo	onth, Di	ay, Year)	
	3	-	I Chihe agen	me			Ri	R421	6114			DEC	EMBER	29	200	4
			30. Name and address of person who				Print)	•						2),	_200	•
6			CHITRA RAJAGOPAL,	- 10				L RO	AD, R	ROCKV	ILLE, I	MD	20855			
	Stat Registra		JAN 03 20	05	strar's Signature	A.	oles									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

6:55A M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

2 No

1 Tyes

TAKOMA PARK Md. 20912

4 Unknown

1X Yes 2 □ No

1. Decedent's Name (First, Middle, Last)

Registrar DHMH 17 Rev 1/2001

State

7600

CARROLL AVE.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIGHTFOOT

3 Registrar's Signature

R. JAMES

31. Date filed (Month, Day, Year)

JAN 0 3 2005

DHMH 17 Rev 1/2001

44-618

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			1 - For State Registrar		State o	f Maryla	nd / Depa <i>Cel</i>	artmen rtificat				lental Hy	giene	004	42837
	.		Decedent's Name (First, Midd	le, Last))							2. Date of De	ath		3. Time of Death
	Physici /Medio		Mary Betty Fle	tche	er							Month Decemi	Day ber 27	Year 7, 2004	
	Examir		4a. Facility Name (If not institution	n, give :	street and nur	nber)		4b. City,	Town, or	Location	of Death			ounty of Death	
			Holy Cross H	ospi	tal			Si	lver	Spri	na		N	ontgom	erv
	Funeral		5. Social Security Number	6. Sex	K	7. Age (In yrs	s. last birthday)	If Under Months		If Under Hours		8. Date of Bir (Month, Da	th		place (State or Foreign intry)
	Director		218-35-2002	11_	M 263xF		94 Yrs.	Working	Days	riouis	Tenti.	Oct. 2		1 .	land
	and **		Usual Residence of Decedent 10a. State 10b. Count	,		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
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	eath	era	11. Marital Status		12. Was Dece	dent Ever in 1	U.S. 13 V		2090:		gin? (Sne	oity Ves or No		gland Race - Amer	ican Indian
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9	Hygi Hygi ther nt.		17. Father's Name (First, Middle	Last)	4			lomema	ker	18. Mothe	r's Name	(First, Middle,		Home	
an	o d to o	To Be	William Silv											,	
Maryland	2 should be and Mental is marked o	Ě	19a. Informant's Name/Relation				19b. Mailir	na Address	(Street a	Ann	e Kl	egg Il Route Numbe	er City or T	own State Zi	n Code)
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altimore,	s 1 and 2 if Health item 27 i		20a. Method of Disposition	1015	OII, Dau	20b.	Place of Dispo	sition /Nan	ne of	1		ver Spr		MD 2091 tion - City or T	
JO	ages ant of tr: # i		1 ☐ Burial 2 ☐ Toremation 1 ☐ Donation 5 ☐ Other (emoval from	state	cemetery, crem	•		· 1	Decen 200	iber 29			
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Вох	that the death certifi ed by the attending I detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	2:	3c. If yes, out	come of pregn	nancy						23d	. Date of deliv	erv
	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	iller I	4 Pregn	inth 2 ∏ Feta ant at time of		Ectopic pro Other <i>(spe</i>						Month	Day Year
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σ,	The law requires that tte has been signed b page 2 should be deta	by P	Part II. Other significant conditi	ons con	tributing to de	ath but not re	sulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use	contribute to t	he cause of death?
ğ	quires in sign uld be											101	′es 2□N	lo 3 ☐ Prot	ably 4 🛣 Unknown
Vital Records,	sw requir s been si s should	Completed										24a. Was		4b. Were auto	ppsy findings available
R	The lav	E O											rmed?	prior to co death?	mpletion of cause of
ta		Φ	25. Was case referred to medica	1						26 Place	of Death	1 ☐ Yes (Check only o	2 X No	1 🗆 Yes	2 No
	Physicien: this certific ral director,	0 B	examiner? 1 ☐ Yes 2 ② No	Н	ospital:	npatient 2	ER/Outpatien	3 DO	A Othe	~		ne 5 Resid		Other (Specif	iv)
o		- E	27. Manner of Death		28a. Date o	f Injury	28b. Time of		Bc. Injury	at		8d. Describe h			y/
<u>o</u>	Attending r death. sctor: Afte by the fune	atio	1 Natural 5 Pendi 2 Accident invest		(MOITE	h, Day Year)	Injury	М	Work	? 'es 2. □ñ	No				
Division	Atte or deg ecto by th	ific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		28e. Place	of Injury - At h	nome, farm, stre	eet, factory,	office		2			umber or Rura	I Route Number,
	s afte	Certification;	4 🗇 Florificide		Duliali	ig, etc. (Speci	ny)					City or Tow	m, State)		
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical (29a. Certifier 1 Certifyi (Check only one)	ng Phys Examin	ician: To the ner: On the ba	sis of examina	owledge, death ation and/or inv	occurred a estigation,	at the time in my op	e, date and inion, deat	place, a	nd due to the o	cause(s) and date and pla	d manner as s	tated. the cause(s)
	o the	Me	29b. Signature and title of certific	r				29c.	License	number			29d. Date si	gned (Month,	Day, Year)
	F > F 0		1719	1	1.D.				D	525	81			/29/	
· •	212	1	30. Name and address of person	who co	moleted cause	of death (Ite	m 23a) (Type I				0		1 ~	1-11	7
	7)							1030	Herl					
	Sta	tė	31. Date filed (Month, Day, Year,	0/0	32. R	gistrar's Sign	Holy Ch	1							
	Registr	-00	DEC 3 0	200	34	Epura	/ /3	ape	Dela						

State of Maryland / Department of Health and Mental Hygiene 004 42838 Certificate of Death Reg. No. 1. Decedenf's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dav **Physician** 31, DECEMBER 2004 NATHAN GUTWERK 2:00 PM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deat Examiner MANOR CARE POTOMAC **POTOMAC** MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. lest birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 € M 2 □ F 99 Director 577-48-1501 05/27/1905 POLAND Usuel Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Pagas 1 and 2 should be filed within 72 hours after death with the Maryler mant of Health end Mental Hygiene.
ant: If Itam 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐XNo MARYLAND MONTGOMERY SILVER SPRING Funeral Director 10e. Street end Number 10f. Zip Code 10g. Cifizen of Whet Country? APT. 816 20910 8201 16TH STREET U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give 14. Race - American Indian, 11 Marifal Stetus Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Completed by 3 Nidowed 4 Divorced Year or Detes: WHITE 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) OWNER LIQUOR STORE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) "UNKNOWN" KRYSTOL "UNKNOWN" 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) RICHARD BENJAMIN/GRANDSON 6517 MILLWOOD ROAD, BETHESDA, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of Important: If It any Injury or o 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State KING DAVID MEMORIAL GDNS:1/4/2005 FALLS CHURCH, VIRGINIA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARÝLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) sudden Examiner Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician end for use es the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasf Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 42 Onknown 1 ☐ Yes 2 ☐ No OUDDE Š eral Director: After this certificate has been signifiled in by the funaral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? 1 Yes 2 HNO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? edicai Certification: 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 Yes 2 No after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-31-04 D31319 0 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

L. ALBIUL, MD 8718 W.S. W. S. L. Bethosch MD 20814

Registrar **DHMH 16 Rev 6/95**

State

31. Date filed (Month, Dey, Year)

JAN 0 3 2005

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760

			1 - For State Registrar	State of Ma		oartment o e <i>rtificate</i> d	f Health and of Death		giene 004	42839
ī	Physic	ian	Decedent's Name (First, Middle, Last,					2. Date of De		3. Time of Death
	/Medi	cal	Albert Arthu		Jr.	T		Decembe		
1	Examir	ner	4a. Facility Name (If not institution, give : 12703 Butte Lane	street and number)			m, or Location of Dea ${ m Lusby}$	ith	4c. County of De	vert
	Funeral		5. Social Security Number 6. Sec		e (In yrs. last birthda	y) If Under 1 Y	ear If Under 24 Hr			rthplace (State or Foreign country)
	Director		300-20-4023]M 2□F	79 Yrs.	Months Da	ays Hours Mir	Aug. 2	27, 1925 We	st Virginia
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary Ind	to	MD Calver	•t	Lusby					1 ☐ Yes 2 ☑ No
	or 288	irec	10e. Street and Number			10f. Zip Coo	ie		10g. Citizen of What C	ountry?
	23a	ral	12703 Butte Lane			20	657		US	A
	er de:	Funeral Director		12. Was Decedent E Armed Forces?		. Was Decedent If Yes, specify (of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. Race - Am Black, Wh	
36	irs aft	by F	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	1 √ Yes 2 □ N If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 🔯	No Specify:		Specify:	White
9-0	72 hours after death with the Maryland Instural', or items 23a or 28a-f ahow dieal Exsoliner cust be trutified at	ted	15. Decedent's Edu	cation	16a. Dec	edent's Usual Oc	cupation		16b. Kind of Business	/Industry
21		Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	+)		one during most of wo tired)			ŕ
121			12 17. Father's Name (First, Middle, Last)		Assi	stant C	omptroller			irconditioni
Maryland 21215-0036	D = 0	o Be		Goff. Sr.			Arietta		Maiden Sumame)	777.
ary	2 should be and Mental la marked aumatic ev	F	19a. Informant's Name/Relationship (Ty)			ling Address (Str			er, City or Town, State,	Tippett Zin Codel
	ss 1 and 2 should of Health and Men itam 27 Is marke other traumatic		Theresa Goff (wife	e)			Lane Lus		20657	
Baltimore,	of He of He If itan		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place of Dis	oosition (Name or ematory or other	T	ary 4	20c. Location - City or	Town, State
ij	Pag tment tant:		`4 ☐ Donation 5 ☐ Other (Specify)		Lakemont			005	Davidsonv	ille, MD
Bal	permit. Pages Department of I Important: If its any injury or of		21. Signature of Funeral Service License			22. Name and Ad	dress of Facility Le	e Funera	1 Home Cal	vert, PA
			23a Part Enter the disease, or combin		the death. Do not e	125 Sou	thern Mary	land Blv	d. Owings	, MD 20736
Le	Physician		Immediate Cause (Final	e cause on each im	tastatic		lanom		rest,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		consequence of):		XUNOW	1		
	Examiner		Sequentially list conditions, b							
	per jisit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	axecul and al-trar	xan	that initiated events resulting in death) Last	Due to (or as a	consequence of);					
8760,	cate be executed physician and the burial-transit	dlcal E	d		, ,					
	rtificat ng phy as th	Medi	JESSIALS AL/A							
Вох	The law requires that the death certific tite has been signed by the attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE: N/A 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o		□Ectopic pregna	ncv		23d. Date of de	ivery
0.	ne dea the at hed fo	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at t 9☐Unknown		Other (specify,			Month	Day Year
P.O.	that the de led by the a detached f	h h	Part II. Other significant conditions con	tributing to death bu	t not resulting in the	underlying cause	given in Part I	23e Did to	bacco use contribute to	the cause of death?
Division of Vital Records,	w requires to been signer should be	d by		TERY	DISEAS		given in react,	1 □ Y		obably 4 Unknown
CO	law requas been 2 should	olete						24a. Was a	an 24h Were au	itopsy findings available
Re	The la	Completed						autops perfori	sy prior to death?	completion of cause of
ita		Bec	25. Was case referred to medical examiner?				26. Place of Dea	1 ☐ Yes :		2 No
of <	ding Physician: .r. After this certifica funeral director, I	2	1 ☐ Yes 2 ☑ No	ospital: 1 Inpatien		nt 3 DOA		lome 5 Meside	ence 6 □Other (Spe	cify)
ou c	ding F	lon	27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	٧		28d. Describe ho	ow injury occurred	
isi	ottan deatl ctor: y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	y - At home, farm, s		Yes 2 No	28f Location (St	treet and Number or Ru	um l Pauta Alice to
2	alor/ s after Il Dira	Certification:	4 Homicide determined	building, etc.	(Specify)	reet, factory, offic	~	City or Town	n, State)	rai noute Number,
	To the Hospital or Al within 24 hours after To tha Funaral Dirac completely filled in by		29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin	ician: To the best of	my knowledge, dea	th occurred at the	time, date and place	, and due to the ca	ause(s) and manner as	stated.
	the H nin 24 tha Fi nplete	ledical	one)	er: On the basis of e	Adminiation and/or i	ivestigation, in m	y opinion, death occu	irred at the time, d	ate and place, and due	to the cause(s)
	To To Con	Σ	29b. Signature and title of certifier			29c. Lice	ense number	i	9d. Date signed (Monti	
		-	20 Mars and a state of			1017	57800		12/30/	· ·
1	7+1		30. Name and address of person who cor	THRAE	atn (Item 23a) (Type 5711	SARUIC	AVE. RI	VER DAL	E, MD20	737
	Sta	te	31. Date filed (Month, Day, Year)	32. Registry	's Signature	- 11/VIS	110-1111		7 5 =	1-1
	Registra	ar	JAN 03	2005	sever St	Goule	D			

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		,,		- State Registrar			Cer	tificate o	f Death		Rag. N	4004	42040
		Diam'r.		1. Decedent's Name (First, Middle,	Last)					2. Date of De	aath Da	ay Year	3. Time of Death
		Physici /Medic		Richard H	White	Gardne	er			Dec	25		4:30 PM
		Examir		4a. Facility Name (If not institution,	give street and nu	m <i>ber)</i>		4b. City, Town	, or Location of Deatl	1	40	. County of Death	1
				Genesis Healt	h Care		Pines		ston			Talbo	
		Funeral		5. Social Security Number	S. Sex	7. Age (In yrs.		If Under 1 Yes Months Day		(Month, Da	ay, Year	9. Birth	place (State or Foreign intry)
	ш	Director		221-05-1927	1 ⊠ M 2□F	92	Yrs.			July 1	6,19	12 Mary	
		p ,		Usual Residence of Decedent		10a Ci	ty, Town or Lo	ention					10d. Inside City Limits
		aryfa show	_	10a. State 10b. County		100. 01	ty, rown or co	Cation					1 ☐Yes 2 ☐ No
		Me Ma	cto	Maryland Talbo	<u> </u>	Ea	aston						1 1 1 1 2 1 1 1 0
		th th	Directo	10e. Street and Number				10f. Zip Code	9		10g. C	itizen of What Cou	untry?
		23e		Dutchmans	Lane			2	1601			USA	
		dea	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	l.S. 13. V	Vas Decedent of Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puerl	pecify Yes or No o Rican, etc.)	D-	14. Race - Amer Black, White	
	9	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28e-f show the Medical Extrainer must be recitled at	J-	1 Never Married 2 Marrie				Yes 2011				Specify:	,
C .	8	rei',	d by	3 ☑ Widowed 4 □ Divorced	Year or I	Dates:							lack .
Gardner	215-0036	72 h netu	etec	15. Decedent's (Specify only highest	Education grade completed		(Give	lent's Usual Oct kind of work do	ne during most of wor	rking	16b. l	Kind of Business/I	ndustry
dr	21	thin e.	du	Elementary/Secondary (0-12)		1-4or 5+)	life. L	OO NOT use ret	ired)	•			
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Ö	/la	should be nd Mental marked o	P	Danie1	Gardner				F1o:	rence	Hin	es	
ar	Maryland	and and s m		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	g Address (Stre	et and Number or Ru	ıral Route Numb	er, City	or Town, State, Z.	ip Code)
chard		l and 2 Health Im 27 in		Phyllis Haines	s / Cous				Dr., Wil	nington,	De1	aware 19	801
Ri	J.	of He of Herr		20a. Method of Disposition			Place of Dispo cemetery, cren	sition (Name of natory or other p	olace) 01/0	3/2005	20c. L	ocation - City or T	Town, State
1-5-1	Baltimore,	Perz		1 🖫 Burial 2 ☐ Cremation : 1			cv1and	Veteran	s Cem 01/	•	Bei	ulah,MaR	YI.AND
	alti	permit. Departmitimporte any inju		21. Signature of Funeral Service L	censee				dress of Facility Smith Ful				
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				23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that	caused the dea	th. Do not ent						Approximate Intervat Between
		Physician		Immediate Cause (Final	nily one cause on	De el D			. 1/				Onset and Death
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	89	ficate phy is the											
	Box 68	certi	/W	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn					i	23d. Date of detin	very
	ĕ	atter	ciar	in the past 12 months?		birth 2 Feta nant at time of		Ectopic pregna Other (specify)				Month	Day Year
	Ö	the d y the	Physician/Med	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkr	nown							
	ط	that ed by deta	/P	Part II. Other significant condition	s contributing to	death but not re	sylting in the ű	nderlying cads	given in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
	ds	uires sigr ld be	d by	MAN	MOS	und	LA.	suff!	CHENCE	1 1 0	Yes 2	No 3□Pro	bably 4 Unknown
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	3ec	e lav has	Completed					w		auto		prior to o death?	ompletion of cause of
	a	icate								1 ☐ Yes		1 ☐ Yes	2 No
	Division of Vital Records, P.O.	iciar certif ecto	Be	25. Was case referred to medical examiner?	Hospital:				0.1	ath (Check only			
	of	Phys this al dii	T _o	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatien	t 3LI DOA	4 Nursing F	lome 5 Resi		6 ☐Other (Spec	ify)
	L	fing After funer	lon	1 Natural 5 ☐ Pending	(Moi	nth, Day Year)	Injury	V	Vork? ☐ Yes 2 ☐ No	Log. Bosonia	11011 1111	,,, 00001100	
	Sic	ttend death tor: the	icat	3 ☐ Suicide 6 ☐ Could no	ot be	e of Injury - At h	nome form str			28f Location /	Street a	nd Number or Ru	ral Route Number,
)i<	or A after Direction by	Certification;	4 Homicide determine	build build	ding, etc. (Speci	ify)	oot, lactory, only	V-G	City or To			
		pitel ours a murs a		29a. Certifier 1 Certifying	Physician: To th	a bast of my ka	oudedge death	accurred at the	e time, date and place	and due to the	001100/	and manner as	etated
		Hos 24 hc Fun stely	Medical		xaminer: On the				y opinion, death occu				
		To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Me	29b. Signature and title of certifie	10	11	7)	29c. Lice	ense number		29d. Da	ate signed (Month	, Day, Year)
		F 3 F ŏ		· Diff	7711)	Mh	J .	7	ファナフト	7	1 -	1/2-1	4.1
				30. Name and address of person v	the completed co	ise of death /Ite	m 23a) (Tupe	Print)	21/1		10	717/6	ny
				ROBIGET STATE	167 MM	508	TOLL	MILLI	ANNUL?	EAS	To	MI	21601
		51	ate	31. Date filed (Month, Day, Year)		Regi st rar's Sign	-	A 1 - A m	, , , , , , , , , , , , , , , , , , , ,	7	1010	,	
		Regist		DEC 2	9 2004	19-7-1	10	-					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death ^{Day} 24 2004 **Physician** Charles H. Holland December 1636 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Jan 17 6 SAY Funeral Birthplace (State or Foreign Country) 1 M 2□F Days Hours Min Year) 931 73 Yrs. Director Maryland 217-26-3862 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d, Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mudical Exercitival for recifical at Maryland 1X Yes 2 □ No Anne Arundel Churchton Direc 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5560 Deale Churchton Rd. 20733 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iten any injury or other traumatic event, the Mudical Evarques Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: Black ð 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Mechanic Dixon Motor Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Holland Bernadine Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loretta Holland(Wife) 5560 Deale Churchton Rd. Churchton, Md. 20b. Place of Disposition (Name of Chemistery Grant Place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 12-31-04 Owensville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. Lavry S. Rees MOGY8 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit the death certificate be executed Due to (or as a consequence of) ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 N6 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ PR/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 💥 🖰 o 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred al or Attending F s after death. After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funerel I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) of certifier 29d. Date signed (Month, Day, Year) 29b. Signar 29c. License number D57028 12-28-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave Ste. 231 Anna polis, mD. 21401 ADITY ACHOPRAM. D. 600 Ridgeli egistrar's Signature 31. Date filed (Month, Day, Year) 32 State DEC 3 0 2004 Registrar

			For State	State of Ma	ıryland	_				ınd M		- 1	201	01.	100	010
			Registrar 1. Decedent's Name (First, Middle, Last)			Cei	tificate o)I L	<i>Jeain</i>		2. Date of Dea	Reg. No		U 4	3. Time of	Dogth .
ı	Physici	an		ward Ha	rol.	а u-	ase				Month December	Day	1 3	Year 2004	6:50	a M
	/Medic		Henry Ho 4a. Facility Name (If not institution, give s		1101	и па	4b. City, Tow	m or i	l ocation o	f Death	Decemb			of Death	0.50	a
	Examin	er •	Calvert Memorial H				Princ				ς		alve			
	Funeral		5. Social Security Number 6. Sex		(In yrs. la	ast birthday)	If Under 1 Ye	ear	If Under 2	24 Hrs.	8. Date of Birt	h		9. Birthp	lace (State o	or Foreign
	Director		244-50-3853 ¹ X	M 2□F	66	Yrs.	Months Da	ays	Hours	Min.	Mar. 3	y, _{Year)} 0 , 1	938	Mic	higan	
	pr .		Usual Residence of Decedent		10 01									- 1		
	uryfar show	_	10a. State 10b. County		10c. City,	, Town or Lo	cation								0d. Inside Ci 1 ☐ Yes	
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	er de Itam	nu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N		3.	f Yes, specify (Cuban	n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)			k, White,		
36	rs aft	by F	3 Widowed 4 X Divorced	If Yes, Give Year or Dates:			1□Yes 2🖔	No	Specify:				Specify	whi	te	
21215-0036	72 hours after death with the Maryland naturel', or Itams 23a or 28a-f show dical Examinat must be notified at	ed	15. Decedent's Educ	cation	1	16a. Dece	dent's Usual Oc	ccupa	tion			16b. Ki	nd of Bu	ısıness/ln		
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g	al Hy sother	Be (17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden	Sumam	10)		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	2	Henry H.	Haas	e	,		-	The						rnson	
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altimore,	it. Partmer		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 		Met		tan Cre				31-04	ATE	xanc	dria,	VA	
Ba	Department of the population o		11.00.00	3 9/100		1					e, P.A.	- Ow	inas	. MD	2073	86
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	Physician		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each lin	e.	10-	~								Onset and	
	/Medical		disease or condition resulting in death)	Due to (or as	consequ	ence of):	5								ч ачу	5
	Examiner		Sequentially list conditions	Pne	um	onio	2								5 da	Y5
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90,	oe execian a	E	resulting in deathy cast	Due to (or as	a consequ	ence or):			·	•						
8760,	death certificate be executed e attending physician and ind for use as the burial-transit	edicai		l												
9 X	eath certific attending pl for use as I	/Me	IF FEMALE: 2	3c. If yes, outcome	of pregnar	ncv							23d Dat	e of delive	any.	
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P.O.		Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown												
	law requires that the as been signed by th 2 should be detach	by Pł	Part II. Other significant conditions con	ntributing to death bu	it not resu	Iting in the u	nderlying cause	e give	n in Part I.		23e. Did to	obacco u	se conti	ribute to th	ne cause of d	leath?
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sio	Attanding r death. actor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	Do Division of Labor	A11				′es 2 □ l		706 1 cention /6	***** * * * * * * * * * * * * * * * *	ad Alexandra	24.24 (1)	1 Courte Mires	
Division of Vital Records,		ertification:	4 Homicide determined	28e. Place of Inju- building, etc	: (Specify	me, tarm, str	eet, factory, off	TIC9			28f. Location (S City or Tox			er or mura	i Houte Num	per,
	spite ours serei	O	29a. Certifier 1 Certifying Phys	sician: To the best of	of my knoy	wiedge, deat	occurred at th	ne time	e. date an	d place.	and due to the	cause(s)	and ma	nner as s	tated.	
	To the Hos within 24 ho To the Fun completely	edical	(Check only 2 Medical Exemitions)		examinati)
	To the within 2. To the Complet	Me	29b. Signature and title of certifier						number		-	29d. Dat	e signed	d (Month,	Day, Year)	
			by an	C m	~UN	α.	D	5	06	53		12	-3	1 - 6	2004	
			30. Name and address of person who co				Print) Gy	(1)	n -e	. 5	urana	,		· · · · · · · · · · · · · · · · · · ·		
	10		5851 - Deal-	e churc	ho	m	Road		De	aje	m	D.	20	757	<u>'</u>	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Day **Physician** Margaret M. Herbert 12-30-2004

4b. City, Town, or Location of Daath

4c. County of /Medical 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Cumberland Potomac Haven Personal Care Home Alleg. If Undar 1 Yaar Birthplace (State or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sax **Funeral** Months Days Hours 1□ M 2₽F Yrs. Jan. 1 1910 Director 183-26-6565 WV Usual Residence of Dacedant Peges 1 and 2 should be filed within 72 hours efter death with the Marylend 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County if Health and Mentel Hygiene. Item 27 is marked other than "natural", or items 23e or 28a-f show other traumstic event, the Modical Experient must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Alleq. Cumberland MD 10f. Zip Coda 10g Citizan of What Country? 10e. Street end Number 205 South St. 21502 USA 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Yes 2 No If Yas, Giva X Yaar or Datas: 1 Navar Marriad 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ᡚ No Specify: Black Spacify δ 3 → Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Spacify only highast grade complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Housekeeper Domestic 18. Mother's Nama (First, Middla, Maiden Sumama) 17. Fathar's Name (First, Middla, Last) Be Zanes A. Gilmore Sadie Gaiter 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 205 South St. Cumberland, MD. 21502 James E. Gilmore Jr. Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata Dapartment of F Important: If Ite any Injury or ott 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Thorn Rose Cem. 1-3-05 Keyser. WV. 21. Signature of Funera Service License 22. Nama and Addrass of Facility Fredlock Funeral Home 31 Jones ST. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Daath Physician /Medical Immediata Causa (Final disaasa or condition resulting in death) Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Due to (or as a consequance of) Division of Vital Records, P.O. Box 68760, Dua to (or as a consequance of): signed by the a 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I. 3 Probably 4 ☐ Unknown 1 Yes 2 No ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 1 ☐ Yes 2 ☐ No 1 TYes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Stother (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours aftar death.

To the Funeral Director: After thi
completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Mennar of Daath 28a. Data of Injury (Month, Day Year) 28b. Tima of 5 Pending investigation 1 Netural 1 Yes 2 No 2 ☐ Accidant 6 Could not be determined 3 ☐ Suicida 28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 4 ☐ Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the causa(s) and manner as steted.
2 Medical Examinar: On the basis of exemination end/or invastigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and mannar statad. 29a. Cartifiar edicai (Check only one) To the 29d. Data signad (Month, Day, Yaar) 29c. Licensa numbar 29b. Signatura and title of certifiar D58853 5 30. Name and address of person who complated cause of death (Item 23a) (Type, Print) Ove Cumberland mp 21502

Registrar **DHMH 16 Rev 6/95**

State

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JAN 0 4 2005

31. Data filed (Month, Day, Year)

32. Redistrar's Signatura

Pennsylvania

			1 - State Registrar	State of Ma	aryland		artment rtificate			and Mental I	Hygiei Reg.	200	-}	42844
			1. Decedent's Name (First, Middle,	Last)						2. Date of Month		Day Ye	ear	3. Time of Death
	Physici /Medio		SHIRLEY P.	HALL						DECEM		26 200		2006 ^M
	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, To	own, or l	Location of	of Death		4c. County of I		
			MEMORIAL HOSP						STON				'ALB	
	Funeral Director		220-32-1660	6. Sex 7. Ag 1 ☐ M 2 [X] F	69 (In yrs. Ia	ast birthday) Yrs.	If Under 1 Months	Days	If Under Hours	Min. 8. Date of Month	Birth Day, Ye 1935	9. 0		ace (State or Foreign YLAND
	and wo		Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	cation						10	Od. Inside City Limits
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	1 the	Funeral Director	10e. Street and Number		1		10f. Zip C	Code			10g.	Citizen of Wha	t Count	try?
	23e o	aiD	1102 RIVER VIEW	TERRACE				2	1663			USA		
	dea	ner	11. Marital Status	12. Was Decedent Armed Forces?		3. 13. \	Was Deceder	nt of His	spanic Orig	gin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race Black, \		
9	or Ite	F	1 Never Married 2 Marrie				1 ☐ Yes 2		Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			WHI	
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<u>la</u>	should be filed within 72 hours after death with the Marylan ad Mental Hygiene. marked other then "neturel", or Items 23e or 28e-f show marked other then "neturel" or Items 23e or 28e-f show marke event, its Madical Examinar	ToB	JAMES L. POWE	LL					EV	A E. APPL	EBAU(GH 		
Maryland	2 4 5 5	0. 4	19a. Informant's Name/Relationsh	,			-			or or Rural Route Nu				Code)
	1 and Health em 27		LYNN H. TYLER/	DAUGHTER	20h Bla		5 CORI		PARK	WAY EASTO	1			State
altimore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		Cei	metery, cren	natory or oth	er place	1			Location - Cit		
Ħ	it. Pag rtment rtant: I njury o		* 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L		CHE					TR 12-27-				
Ba	Depa Impo any I		Joseph M.	Ostroush'	CFS	20	00 S. 1	HARR	RISON	BEIN & NE	N, M			
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	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):	e de	351	hst	4 hmia				5min.
	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a conseque	ence of):	us 19	h t	en	Di5-00	re		v	inhowers.
o Ô	te be executed ysician and re burial-transit		resulting in death) Last	Due to (or as	a conseque	ence of):	/ -	,	/	· (tre	. 1.	()		5710
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Box	at the death certifical by the attending phi tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal o	death 3□	Ectopic preg Other (spec				_	23d. Date of Month		y Day Year
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II Records,	The la	Completed						-		p	tas an utopsy erformed s 2 121	prior	to com	sy findings available pletion of cause of
of Vital	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:					-	of Death (Check on				
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C	ting Afte fune	tion	1 Natural 5 Pending		y Year)	Injury	M	D. Injury a Work?	? es 2⊟t		36 11011 111	lary occurred		
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not determine	ot be	ury - At hor c. (Specify)	ne, farm, stre	eet, factory, o			28f. Locatio	n (Street Town, Sta		r Rural	Route Number,
	Hospite 24 hours Funerel	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminer: On the basis of and manner sta	f examination	rledge, death on and/or inv	occurred at restigation, in	the time	a, date and nion, deat	d place, and due to the tine	he cause ne, date a	(s) and manne and place, and	r as sta due to t	ted. the cause(s)
	o the o the omple	Me	29b. Signature and title of certifier	and mainer ste			29c. l	License	number		29d. [Date signed (M	fonth, D	ay, Year)
)	⊢ s ⊢ ō		> nata	5 00			M	42	50	(my)	1 2	126	120	204
			30. Name and address of person w		leath (Item :	23a) (Type,	Print)	(-		Kny)	-			
			Russell A	Schilling .	97	555	Cyn	wo	ed K	W Eas	ton	md 2	16	0/
	Sta Regístr	_	31. Date filed (Month, Day, Year)	32. Régistra	ar's Signatu	ire A	and s							

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death Amended, 31 &32, per TCHD, 12/28/2004, sbb 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Dey Month **Physician** MARGARET A. HALL DECEMBER 23 2004 3:25 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner MILLENIUM NURSING & REHABILITATION CENTER ELLICOTT CITY HOWARD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. J.N. 13 1914 9. Birthplece (State or Foreign Country) MARYLAND 7. Age (In yrs. lest birthday) 6. Sex 5. Social Security Number **Funeral** 1□M 2 F 90 185-09-2713 Director Usuel Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hyglene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. YE Yes 2 No ELLICOTT CITY MD HOWARD Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 3000 N. RIDGE RD 21043 **IISA** 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Detes: 11. Merital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 🏋 No Specify: Specify: WHITE à 3 □XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) EARL HALL MARGARET GILMAN 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JOHN H. HALL/SON 4600 LINCOLN DR BALTIMORE, MD 21227 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY 12-30-2004 EASTON, MARYLAND 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 MERLERON 101th 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** EREBRO VASCULAR /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or es a consequence of) by Physician/Medical Examiner attending physician and for use as the bunal-transit Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 □ Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No After this certificate has been signifunaral director, paga 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy Be Completed 2 DING 1 ☐ Yes 2 ☐ No ↑L Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 4☐ Mursing Home 5☐ Residence 6 ☐ Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Naturel 5 Pending investigation s aftar daath. 1 ☐ Yes 2 ☐ No 2 Accident the th 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funeral Di completely filled in Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29a. Certifier Medical (Check only the th 29d, Date signed (Month, Dev. Yeer) 29b. Signature end title of certifier 29c. License number 23 Johnson 04 shoen 30 Name end eddress of person who completed cause of deeth (Item 23e) (Type, Phint) MINEBM AKHAN 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar

DHMH 16 Rev 6/95

Charles Hawkins 04-08360 MLO

MLO nen <u>ded, 20a, 20</u>	State of Maryland / Department of Health and Mental Hygiene 1- State of Death Certificate of Death Reg. No. 004 4284	
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) McKinley Charles Hawkins 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death	eath M
Funeral Director	5. Social Security Number 213-42-2471 Rock Hall Rock Hall Kent Frage (In yrs. last birthday) 1027 M 2 F F S9 Frage (In yrs. last birthday) Yrs. Rock Hall Kent S. Date of Birth (Month, Day, Year) (Month, Day, Year) March 18,1945 Maryland	Foreigr
a-f show lifted at	Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Maryland Kent Rock Hall 1 □ Yes 2	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Medical Evantinating the notified at once. To Be Completed by Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11g. Citizen of What Country?	
21215-00 ed within 72 hou ygiene. Internal "naturur t. In Predical Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Never Worked 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Never Worked	
Maryland 21215-0036 nd 2 should be filed within 72 hours att th and Mental Hygiene. 27 is marked other than "natural", or traumatic event. The Medical Exert To Be Completed by F	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
Baltimore, War bernit. Pages 1 and 2 st Depertment of Health and moortant: If Item 27 Is n my injury or other treun page.	Anthony Hawkins / Brother 20a. Method of Disposition 20a Community 20b Place of Disposition (Name of Community, Community, Community) 20b Place of Disposition (Name of Community, Community) 20c Location - City or Town, State 20c Location - City or Town, Sta	
Balti permit. Depertm Importa any inju	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home Road 298. Chestertown Maryland 21620	
8760, cate be executed by sician and the burial-transit dical Examiner	23a. Part (E)ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tary Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	ath
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n of ng Phy fter this ineral d	examiner? 1 X ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) At Scenario No. 1	
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
To I com	29b. Signature and title of certifier 29c. License number OCME 29d. Date signed (Month, Day, Year) December 27, 2004	
State Registrar	Pamela E. Southell, MD 111 Penn Street, Baltimore Maryland 21201 31. Date filed (Month, Day, Year) 3 0 20032. Registrer's Signature DEC 3 0 20044	

			1 - For State Registrar	State of Maryland	/ Depa		Health and		giene 0	04	428	47
	Physici		1. Decedent's Name (First, Middle, Last)	VIRGINIA HOU	FF			2. Date of Dea		2004	3. Time of D	Death AM
je za	/Medio Examir		4a. Fecility Name (If not institution, give str Northampton Manor No			4b. City, Town	n, or Location of De		Frede	y of Death erick		
ř.	Funeral Director		210 30 3101	7. Age (In yrs. las	st birthday) 7 Yrs.	If Under 1 Ye Months Day		in. Jan. 30	y, Year) 1907	9. Birthp Coun Mary	place (State or etry) Land	Foreign
	rarytand Fahow	or	Usual Residence of Decedent 10a. State 10b. County Maryland Frederick		Town or Loc					1	0d. Inside City	
:	with the h	Funeral Director	10e. Street and Number 200 East Sixteenth		- Cuci ic	10f. Zip Cod	e 701		10g. Citizen of	What Coun	ntry?	
036	be lied within 72 hours after death with the maryland tal Hyglene. tal Hyglene. d other than 'natural', or items 23s or 28s-f ahow avant, I're Medical Evairiner must be notilied at	by	11. Marital Status 12 1 Never Married 2 Married 3 XWidowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	j		is Decedent of Hispanic Origin? (Specify Yes or No- 'es, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No Specify:			ce - Americ ack, White, fy: Whit	etc.	
Maryland 21215-0036	within 72 houne. Than "natura Medical E	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		life. DO NOT use retired)							
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Baltimore,	rages 1 and the notes of the no		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Ref 4 □ Donation 5 □ Other (Specify)			sition (Name of atory or other p vet Cer		3/05 F	20c. Location	-		
Balti	permit. Pages 1 Department of H Important: If itel any injury or ott		21. Signature of Funeral Service Lice	1 1 -100				& SON FUN				
			23a. Part1. Enter the disease, or complications, or heart failure. List only one Immediate Cause (Final		Do not ente	er the mode of o	dying, such as card	liac or respiratory ar	rest,		Approximate Interval Betwee Onset and De	eath
	mysician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseque		<u>१</u> १८८४	B (BWV)	57,68)			75 ye	ers
	nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events c.	Due to (or as a conseque								
	cate be executed physician and the burial-transit	cai	resulting in death) Last	Due to (or as a conseque	ince of);							
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Division of	or Attending Physician: ifter death. Diractor: After this certific in by the funeral director,		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	V	njuryat Work? □Yes 2□No	28d. Describe h	low injury occur	rred		
DIVIS	tal or Attending in safter death. al Diractor: After ed in by the funeral in the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stre	et, factory, offic	СӨ	28f. Location (S City or Ton	Street and Numi m, State)	ber or Rura	l Route Numbe	∍ Γ,
:	ne Hospital on 24 hours af he Funeral Dietely filled in	Medical	29a. Certifier (Check only one) Certifying Physic 2 Medical Examine	cian: To the best of my knowler: On the basis of examination and manner stated.	edge, death in and/or inv	occurred at the estigation, in m	e time, date and pla ny opinion, death oc	ace, and due to the occurred at the time, o	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)	
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			30. Name and address of person who com			Print)		ue mo	2179			
	Sta Registi		31. Date filed (Month, Pay, Year)	32. Registrar's Signatu	re S	Coally s	A CACCICO	/0	2179	<u>J</u>		

		•	For State Registrar	State of Maryland /		rtment of He tificate of D		nd Mental H	ygiene Reg. Ne	HILL	42848
			1. Decedent's Name (First, Middle, Last)					2. Date of I	Da	y Year	3. Time of Death
	Physicia /Medic		Clifton John	Hebert				Dec.	26,	2004	2:45 p M
	Examin		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or I	Location of	Death	40	. County of Dea	ith
			Civista Medical	Center		LaPlata,			C	Charles	3
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bi	* '	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, I	Day, Year		thplace (State or Foreign ountry)
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	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Loc	ation					10d. Inside City Limits
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	death ms 2	Funeral Director	11. Marital Status	. Was Decedent Ever in U.S.	13. V	as Decedent of His	panic Origi	n? (Specify Yes or I Puerto Rican, etc.)	No-	14. Race - Am	
9	after or ita	Ē	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give	1	Yes 2XNo	Specify:	Puerto Fican, etc.)		Black, Whi	White
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Maryland	should ind Men inarke umatic	은	19a. Informant's Name/Relationship (Type	. Print) 19	b. Mailin	Address (Street a		or Rural Route Nurr			Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Mcdical Examiner must be intillised at ODGE.		John Hebert/Son		34 H	lertz Ro	ad,	Deville,	LA.	71328	
altimore,	Head Head Item		20a. Method of Disposition	comate	of Dispos	sition (Name of atory or other place	,	Date	20c. L	ocation - City or	Town, State
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г			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. Do cause on each line.	not ente	r the mode of dying	, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between
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687	flicate g phy as the	0	d.								
Вох	nding use	N/	IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome of pregnancy	- 20	Ci				23d. Date of de	livery
m	that the death certificed by the attending podetached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)			. :	Month	Day Year
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isic	Attending r death. ector: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, f	arm stre				(Street a	nd Number or R	ural Route Number,
Division	after Dire	Certification;	4 Homicide determined	building, etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			own, State		
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	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medical Examine one)	r: On the basis of examination a and manner stated.	nd/or inv	estigation, in my op	inion, death	occurred at the tim	e, date an	d place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License			29d. Da	ate signed (Mon	th, Day, Year)
			MILL			D-273			12	16110	5
4	P.RII		30 Name and address of person who com	pleted cause of death (Item 23a)	(Type, I	Print)	S+ ~	100 17 3		100	20605
\	HUII		31. Date filed (Month, Day, Year)	32 Begistrar's Signature		1 011.	bre	100 Wal	dorf	, MD 2	20602
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 42849 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 20:17 PM 29,2004 Marquerite P. Iannopollo /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard County General Hospital Columbia Howard 8. Date of Birth (Month, Day, Yea Aug 7, 19 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🛣 F New York 78 117 18 0301 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County the Medical Examiner must be notified at 1 Yes 2 XNo NY Ontario Geneva by Funeral Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14456 United States 52 Wadsworth Street 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Plant Manager B & G Foods svant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Patsy Mastroleo Ersilia Pannucci traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages t and 2;
Department of Health ar
Important: If itsm 27 Is:
sny Injury or other traus 52 Wadsworth Street Geneva, New York 14456 Dominic J. Iannopollo/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 12-31-2004 Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 Mice 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) · Acute Myo cardial Ischemia **Physician** Seconds /Medical Due to (or as a consequence of). **Examiner** ardiovascular theroscleratio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner for use as the burial-transit Hyperteusion
Due to for as a consequence of): 1ears Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anerrysm repair 2 🗆 No 3 Probably 4 DUnknown ominal 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 3-No 26. Place of Death (Check only one, funeral director, Be 25. Was case referred to medical 29b. Signature and title of certifier Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 3 Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

and

the attending physician

this certificate has

After

within 24 hours after death. To the Funeral Director: A

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To the Hospital

Maryland

death

2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural" or Ital

t and 2 should

Baltimore, Maryland 21215-0036

Itams 23a or 28a-f show

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) **JAN 04** 2005

PATEYCE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hemlock NO 4565 32. Registrar's Signature

Lepur.

29c. License number

29d. Date signed (Month, Day, Year)

Der- 29, 2004

21042

			1 - State Of Ma		epartment of F Certificate of I			ene O L	42850
			Decedent's Name (First, Middle, Last)				2. Date of Deat	n	3. Time of Death
ı	Physici		CHANG JIN KI	M			Month December	Day Yea r 26, 200	
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	_	4b. City, Town, or	Location of Death	Decembe	4c. County of De	
ı	LXMIIII	-	Collingswood Nursing Cente	r	Roc	kville		Mont	gomery
	Funeral			(In yrs. last birth	nday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		irthplace (State or Foreign Country)
	Director		230.25.2147 ^{1□M 2} The state of the state	87 ^Y	rs. Months Days	Hours Min.	July 20	1917 K	orea
	ъ		Usual Residence of Decedent						
	nylan how		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Ma 9-f s	to	Maryland Montgomery	Germ	antown				1 ☐ Yes 2 🖾 No
	h the	Directo	10e. Street and Number		10f. Zip Code		10	g. Citizen of What	Country?
	h wil	a D	19556 Crystal Rock Drive Ap	t. #11	208	374		U.S.A	•
	deat	Funeral	11. Marital Status 12. Was Decedent 8 Armed Forces?	ver in U.S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-		nerican Indian,
9	n 72 hours after death with the Maryland "neturel", or Items 23s or 28e-f show calcal Extra Inst. rast be ruilled at	by Fu	1 Never Married 2 Married 1 Yes, Give 3 A Widowed 4 Divorced Year or Dates:	lo	1 ☐ Yes 2 ☐ No	Specify:	rican, etc.)	Black, Wi Specify:	Asian
215-0036	hou		15. Decedent's Education	16a. I	Decedent's Usual Occup	ation		6b. Kind of Busines	
Š	c * 3	Completed	(Specify only highest grade completed)		Give kind of work done of life. DO NOT use retired	during most of work	ing		a mounty
	y within jiene. r then "	E C	Elementary/Secondary (0-12) College (1-4or 5		emaker		1	Domestic	
2	bel ya	ပိ	17. Father's Name (First, Middle, Last)	11011	icma kci	18. Mother's Nam			
Maryland 2	d be ontal	00	Gong Lee			Susanna	V 1 m		
2	d Me d Me mark matic	ဥ	Gong Lee 19a. Informant's Name/Relationship (Type, Print)	19h	Mailing Address (Street			City or Town State	Zin Code)
<u>g</u>	12 s h an 7 is r treui								
	ages 1 and 2 should be find of Health and Mental Hit if item 27 is marked ot yo other treumatic ever		Helena H. Lee / Granddaugh					Own Mary.	
Baltimore,	Pages nent of h int: If ite		1 Burial 2 ☐ Cremation 3 ☐ Removal from State	l .	Disposition (Name of crematory or other place)			
	permit. Page Department of Importent: If eny injury or once.		' 4 ☐ Donation 5 ☐ Other (Specify)	Gate o	f Heaven Ce			Silver Spi	ing, MD
ğ	epsr epsr npor ny in		21. Signature of Funeral Service Licensee	-	22. Name and Addres	ss of Facility H	LNES-RINA	ALDI FUNE	RAL HOME, INC
ш	<u> </u>		Narry A. Vecon	ul	11800 New H	ampshire	Ave. Si	lver Spri	ng, MD 20904
			23a. Part1. Enter the disease, or complications that caused shock, or beart failure. List only one cause on each lin	the death. Do no	ot enter the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
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	/Medical		resulting in death)	consequence of		Boase			1 1001
	Examiner								
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	uted d ansit	Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events c						
Ĵ,	exector and and rial-tr	Exa		consequence of):				
98/90	fficate be executed g physicien and as the burial-transit	edical	d						
ρ	ificat g phy as th	ed							
gox	at the death certifii by the attending p stached for use as	an/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		• 🗆 -			23d. Date of d	elivery
ă	death atte	ပ	in the past 12 months?		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
oj.	the c y the ached	hysi	9 ☐ Unknown						
7	requires that een signed b nould be deta	۵	Part II. Other significant conditions contributing to death but	t not resulting in	the underlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ďs,	uires sign	d by	Arterial Fibrildation	1			1 ☐ Ye	s 2 No 3 7	Probably 4 🖾 Unknown
Hecord	> 20 70	ompleted	D 11 1 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4				24a. Was an	24h Were	autopsy findings available
ĕ	e la has	m	Bronchial Asthema				autopsy	prior to	completion of cause of
	: The cate hat page	O					1□ Yes 2		s 2 No
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:		Othe	26. Place of Deat			
0	his I dii	2	1 ☐ 1 €S 2 X NO		patient 3 DOA Othe	+ Es rear sing rio		nce 6 Other (Sp	ecify)
	ding Phys h. After this funeral dii	ertification;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day	Year) 28b. Tii	ury Worl		28d. Describe hor	w injury occurred	
UIVISION	eath cor: /	cat	2 Accident investigation 3 Suicide 6 Could not be			Yes 2□No			
Ë	irect irect	E	4 Homicide determined 28e. Place of Injurbation building, etc.	ry - At home, farr . <i>(Specify)</i>	n, street, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,
	spital or Atten ours after deat nerel Director: filled in by the	O	l l						
	4 4 P P P P P P P P P P P P P P P P P P	edical	29a. Certifier (Check only and Medical Examiner: On the basis of and manner star	examination and					
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier		29c. License	number	29	d. Date signed (Mor	oth, Day, Year)
	3		Kis -		D 2865	6	De	ecember 28	3. 2004
	2		30. Name and address of person who completed cause of de	ath (Item 23a) (T				JUMPUL Z	- , - 0 1
			Ravi Passi, M.D. 15225 Shad	ly Grove	Rd. #208,	Rockville	, Maryla	nd 20850	
	Sta	te			Sparle				
			JAN 0 3 2005	H	CHARLES !				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ () 1 = State Registra PEND#19aperFH1/11/05, RVW, McCo Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** December 26, 2004 6:00 A Martha P. Kohn /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Nursing Home Rockville Montgomery If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 93 yrs If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 X F Director 578-42-0091 July 4, 1911 Brooklyn. NY Usual Residence of Deceden with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show : if item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Madical Examinar must be mortified at 1 Yes 2 No Director Rockville Maryland_ Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20855 USA by Funeral 7416 Ottenbrook Ter filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify. 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Real Estate Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If Item 27 Is marked of Samuel Pomper Dora Pomper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loubier Sandra Laubier/Daughter 7416 Ottenbrook Ter, Rockville, MD 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite sny injury or ot 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens Dec 27, 2004 Olney, MD 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityHines-Rinaldi Funeral Home once. Sal 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** ementra resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ⊠No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 3 been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed 2/1/10 certificate 1 Yes 2 🕅 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this n by the funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 2 🗆 No efter death. investigation 1 Yes 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled within 24 hours To the Funeral 1.7. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29b. Signature and title of certifier C

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DHMH 17 Rev 1/2001

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2005

31. Date filed (Month, Day, Year)

Rockville Pike, G-106, Kockville, INV. 20852

State of Maryland / Department of Health and Mental Hygiene UU4 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month THOMAS KRUZIC December 25, 2004 /Medical 9:40 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hillhaven Nursing Home Adelphi Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 3, Birthplace (State or Foreign Country) **Funeral** Days Months 1⊠M 2□F Hours Yrs. Director 325.07.2725 94 1910 Illinois Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Directo 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with ŏ 10317 Lariston Lane or Items 23e 20903 death Funeral U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. within 72 hours after 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🖾 No þ 3 Widowed 4 Divorced netural Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Importent: If them 27 is marked other the any injury or other traumatic event, the ODEs. Chemical Project Engineer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas P. Kruzic, Sr. Antonia Kuchan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas D. Kruzic / Son 10515 Rolling Green Court, Clarksburg, MD 20871 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ^4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemet 12/29/2004 Silver Spring, Maryland b 21. Signature of Funeral Service Lie 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, conteart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Atherosclerotic Cardiovascular Disease 15 Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760. attending physician IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day 4☐Pregnant at time of death Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by of Vital Records. 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page certificate 1 Yes **⊉**□ No 1 Tes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Division 1 XNatural 5 🗌 Pending after death. 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2. 29b. Signature And title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31563 December 29, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Benner, 10801 Lockwood Dr. #205 Silver Spring, MD 20901 M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

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		1 - For Stata Registrar 1. Decedent's Name (First, Middle, L	State of Mary	land / Dep	partment of learnificate of	Health and	Mental Hygi	ene 200	4 4285
Physici /Medio Examir	cal	4a. Facility Name (If not institution, gi	erly		4h City Town	or Location of Dea	2. Date of Death Month	Day Year 26 0 4c. County of Dea	4 8.40
Funeral Director	ier	Anne Arundel Medi	cal Center	yrs. last birthda; Yrs.	Annapo	lis	8. Date of Birth	Anne Aru	
ith the Maryland or 28a-f show	Director	10a. State 10b. County Maryland Prince 0 10e. Street and Number		c. City, Town or l	Location 10f. Zip Code		10	g. Citizen of What C	10d. Inside City Limit 1 TYPes 2 □ N ountry?
72 hours after death with the Maryland natural", or itams 23a or 28a-f show Jical Eva rinet must be notified at	by Funeral Director	15005 Health Cer 11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	in U.S. 13	20716 Was Decedent of If Yes, specify Cub 1 □ Yes 2 □ No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi Specify:	erican Indian, te, etc.
filed within 72 ho Hygiene. ther than "natu int, II v Wedicell	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ade completed) College (1-4or 5+)	(Giv.	edent's Usual Occup e kind of work done DO NOT use retire e Maker	oation during most of wo d)	rking 1	6b. Kind of Business Own Home	Vindustry
2 should be file and Mental Hy is marked oth sumatic avant	To Be	17. Father's Name (First, Middle, Las Unkno	own	19b. Mail	ling Address (Street	Alice H	me (First, Middle, M Hartigan ural Route Number,	aiden Surname) City or Town, State,	Zip Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic avant, Ital Medical Evaninet must be notified at once.		Kevin Kelly/ Son 20a. Method of Disposition 1 Burial 2 Toremation 3 [4 Donation 5 Other (Species)	Removal from State	6416 Db. Place of Disponentery, cre Huntt Cr	Greig Sti	reet Apt.	302 Capi	tal Heigh Oc. Location - City or Aldorf, Ma	ts, MD 207 Town, State ryland
permi Depa Impo any ir		21. Signature of Funeral Service Lies 23a. Part1. Enter the disease, or com-	4		16000 Anna	apolis Ro	ad Bowie,	ans Funer Maryland	
cate be ohysicia the bui	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cord Due to (or a)	gequence of): Neuman Assequence of): Make the sequence of t	mykemi mia f andal	10	sely condu		Inierval Between Onset and Death
at the death certific by the attending p tached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 □ √0 o 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ If 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3[□Ectopic pregnancy			23d. Date of del Month	ivery Day Year
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this aldi	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	-		ome 5 Residence 28d. Describe how				
1 3 a = 1.	edical Certif	4 Homicide determined 29a. Certifier Check only 2 Medical France	28e. Place of Injury - A building, etc. (Sp	ecify) knowledge, deatl	h occurred at the tim	e, date and place,	City or Town, S	, , , , , , , , , , , , , , , , , , ,	etated
within 24 h To tha Fun completely	Σ	29b. Signature and title of certifier	niner: On the basis of exam and manner stated.		29c. License	number	29d.	Date signed (Month	, Day, Year)
State		30. Name and address of person who TOTY 31. Date filed (Month, Day, Year) DEC 3 0 20	JOSEPH K	TEXBE		D. 20	AMC DIMEDICA	I Pleny.	OY ANNAPOCIS IN 2140

			State of Maryland / State Registrer	Department of Health and Mo	ental Hygien Reg. N	-004 4 -004
	Physicia	_	1. Decedent's Name (First, Middle, Last)	1/ -1 1		ay Year 702 PM
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Occ Lines	c. County of Death
	Examin	er	The Johns Hopkins Hospita	1 Baltimore Citi	-1	•
	Funeral		5. Social Security Number 6. Sex 7. Age (In rs. last bi	rthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign Country)
6	Director		093-24-0113 1□M 2ŒF 76	Yrs. Months Days Hours Min.	(Month, Day, Year 03/30/192	8 New York
	po *	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tov	n or Location		10d. Inside City Limits
	Aaryla F sho	ō				1 □XYes 2 □ No
	the h	Funeral Director	Maryland Anne Arundel Crofto 10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	3e or	ō	1780 Regents Park Road East	21114		SA
	death ms 2	Jera	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F		14. Race - American Indian,
9	after or Ite	Ē	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give	1 Yes 2K No Specify:	rican, etc.)	Black, White, etc.
003	urel',	d by	3 ₩ Widowed 4 Divorced Year or Dates:			Specify: White
215-0036	within 72 hours after death with the Maryland ene. Than "naturel", or Items 23e or 28e-f show he Medical Exantilier must be indiffed at	Completed	15. Decedent's Education (Specify only highest grade completed)	 Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired) 	16b. I	Kind of Business/Industry
212	within ene. then	шс	Elementary/Secondary (0-12) College (1-4or 5+)	Home Maker		Own Home
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lan	ould be Mental arked o	To B	John Cauiston	Helen B	roderick	
Maryland	and and sum		19a. Informant's Name/Relationship (Type, Print) 19	D. Mailing Address (Street and Number or Rural	Route Number, City	or Town, State, Zip Code)
	1 and 2 Health em 27 l	12		2 Cottage Run Davidso		
Baltimore,	0 0		20a. Method of Disposition 20b. Place community 1 Remarks 2 Cremation 3 Removal from State	of Disposition (Name of pry, crematory or other place)	20c. l	Location - City or Town, State
Ë	permit. Pag Department Importent: I any injury o		'4 □Donation 5 □Other (Specify) Vetera	ans Cemetery 12/30		wnsville, Maryland
3a	permit. Pa Departmer Importent any injury once.		21. Signature of Funeral Service Licenses	22. Name and Address of Facility Robe		
	40244		23a. Part1. Enter the disease, or complications that caused the death. Do	16000 Annapolis Road		Approximate
	2 55		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	^	rospiratory arrost,	Interval Between Onset and Death
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87	physic the k	dica	d			
9 X	leath certifica attending ph I for use as th	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
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0	that the de ed by the detached	hys	9 ☐ Unknown			
٦,	es thal igned b	by P	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
rd	v require been sig should b	ed			1 Tes 2	2 No 3 Probably 4 Unknown
Records,	law reas be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E B	siclan: The law s certificate has b lirector, page 2 s	Con			performed?	death? 1 Yes 2 No
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Division	Attendir r death. ector: Al by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, 1	arm, street, factory, office 2	8f. Location (Street a City or Town, Sta	and Number or Rural Route Number,
ā	s afte el Dir	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Sta	(0)
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge one) Medical Examiner: On the basis of examination a and manner stated.			
	To the Comp	Σ	29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
			Sunjay Koushel, MD.	KE2-000	Dece	mber 27, 2004.
			30. Name and address of person who completed cause of death (Item 23a SUNJAY KAUSHAL 100 M. WOLF	(Type Print) E Street 13Altimo	RE MARY	land 21287
	Sta ** Registi		31. Date filed (Month, Day, Year) DEC 3 0 2004 32. Pristrar's Signature	food	/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Stete
Registre Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December Day 28, 2004 **Physician** 7:30A M Joseph Kramer Lawrence /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Nanjemoy 9680 Adams Willett Rd. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 9. 54 Yrs. September 27, 1950 9. Birthplace (State or Foreign $0^{Country)} PA$ 5. Social Security Number 6. Sex 1 M 2 ☐ F **Funeral** 172-38-6845 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exact and retruit be rectified at any injury or other traumatic event, the Medical Exact and retruit be rectified at any injury or other traumatic event. 10a. State 10b. County 1 ☐ Yes 2 No Director Charles Nanjemoy MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20662 9680 Adams Willett Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed ♣ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bradley Jean Helen Thomas Merle Kramer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9320 Bastable Mill Rd. Catlett, VA 20119 19a. Informant's Name/Relationship (Type, Print) Natallie Kramer/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Shiloh Methodist Cem. 1/3/05 Bryans Road, MD 21. Signature of Funeral Service Licensee 22 AREHART ECHOLS FUNERAL HOME, P.A P.O. BOX 567 LA PLATA, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Ischemic heart disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Examine sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2□No ို this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral I
completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0050883 12/29/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yahia Tagouri, M.D. 11655 Winesapp Place, La Plata, MD 20646 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 3 0 2004 WINTER. Registrar DHMH 17 Rev 1/2001

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	si ²	Registrar 1. Decedent's Name (First, Middle, Last)	Cerun	icale of Dealif	Reg. N	0.	3. Time of Death
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Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If	Under 1 Year If Under 24 Hrs. onths Days Hours Min.	Date of Birth (Month, Day, Yea	G. Birtl	nplace (State or Foreign untry)
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and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	on			10d. Inside City Limits
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show empty injury or other treumetic event, the Marial Examine to wither notified at once.		You Glang Kim	(Son) 11047	Buch Tras	are Lau	uel Mi	20723
Sec H Sec P		20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal	from State 20b. Place of Disposition cemetery, cremato	n (Name of ory or other place)	Date 20c.	Location - City or	Town, State
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spitel cours nerel filled		29a. Certifier 12 Certifying Physician:	To the best of my knowledge, death oc	curred at the time, date and place,	and due to the cause(s) and manner as	stated.
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medical Examiner: On	the basis of examination and/or invest manner stated.	igation, in my opinion, death occur	red at the time, date a	nd place, and due	to the cause(s)
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	1	1 /200	(n)	D0021033		ember 3	1, 2004
(2)		30. Name and address of person who complete	cause of death (Item 23a) (Type, Prin		MP		
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			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
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	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		•	NORTHWEST HOSPITAL	RANDALLSTOWN		BALTIMORE	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth <i>Cou</i>	place (State or Foreign ntry)
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	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	Location			10d. Inside City Limits
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	the 288-	Director	MARYLAND PRINCE GEORGE'S CAPITOL 10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
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Balt	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Mars 308 Suitland Road S	hall's Fi	uneral Ho MD 2074	
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n c	ding Physicien: n. After this certific funeral director,	on	27. Manner of Death 1 XNatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	3d. Describe how in	ijury occurred	
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	spital or nours afte neral Dir r filled in		29a. Certifier 1X Certifying Physician: To the best of my knowledge, dea	ati occurred at the time, date and place, an			tated.
1	na Hospital or Attand 24 hours after death ne Funeral Diractor: sletely filled in by the		29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, dea control on the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred	d at the time, date a	and place, and due to	tated. o the cause(s)
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		For State Ragistrar	State of	f Marylan		artment				lental Hy		04	42858
a		Decedent's Name (First, Middle, L.)	ast)							2. Oate of Dea		Year	3. Time of Death
Physic /Med		George Kueh	nle, Jr.							Decemb	er 27, 2	2004	10:30 P M
Exami		4a. Facility Name (If not institution, gi		nber)				Location of	of Death		4c. County		
		Millenium South 5. Social Security Number 6.		7. Age (In yrs. I	last birthday)	If Under	gewa 1 Year	If Under	24 Hrs.	8 Date of Birt		9 Aru	
Funeral Director		578-68-2908	13 X M 2□F		4 Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Day Feb. 27	y, Year)		place (State or Foreign ntry) 7 York
ס		Usual Residence of Decedent		40.00									
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the M	Funeral Director	Maryland Montgo	omery	5	ilver	Sprin 10f. Zio				· · · · · · · · · · · · · · · · · · ·	10g. Citizen of V	/hat Cour	
3e or	Di	11308 Baritone	Court				0901				US		
death	nera	11. Marital Status		edent Ever in U.	S. 13.\				igin? (Spe	ecify Yes or No- Rican, etc.)			can Indian,
or Ite	y Fu	1 Never Married 2 Married	1X Yes	2 No		1 🗆 Yes 2		Specify:		1110211, 010.)		Whi	
hours turel',	ed by	3 Widowed 4 Divorced	Year or D	ates: 1000	16a, Dece	lant'e Heus	LOccupa	tion			16b. Kind of Bu		
in 72 n "na	ompleted	(Specify only highest g	rade completed)	400 5 1)	(Give	kind of wor DO NOT us	k done d	uring mos	t of work	ing	TOD. KING OF BU	131110534111	uustry
d with d with giene.	E	Elementary/Secondary (0-12)	College (1		Att	orney					Law		
dilic X IX IS-0000 d be filed within 72 hours after death with the Maryland shall Hygiene. sed other then "naturel", or Items 23e or 28a-f show c event, the Medical Evantiner must be multified at	Be C	17. Father's Name (First, Middle, Las								•	Maiden Sumam	•	-
Via lould b Ment warked	2	George Kuehnle									beth Cam	-	
MCAING 2 Sh th and th and treum		19a. Informant's Name/Relationship Beth E. Livingst		cutrix		•					or, City or Town, MD 21037		Code)
Healt Healt tem 2		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nam	ne of			Date	20c. Location -		own, State
Pages ent of nt: If i		1 🗷 Burial 2 □ Cremation 3 3 4 □ Donation 5 □ Other (Spec		State G	emetery, crer ate of Ceme	Heav	en	<i>"</i>	ecem 200	ber 30 04	Silver S	prin	g, Maryland
paritimore, interpretation 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23e or 28a-f show any injury or other treumatic event, the Medical Examination and once.		21. Signature of Funeral Service Lice	ie Par	ker	F	raneri					l Home I ilver Sp		, MD 20901
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that o	aused the death	n. Do not ent	er the mode	e of dying	g, such as	cardiac (or respiratory ar	rest,	T	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		cer of	Lung w	ith M	etas	tasis	S				Onset and Death
/Medical Examiner		resulting in death)	w	(or as a conseq					-				
ΔΑ		Sequentially list conditions,		eral De									
uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,	,							1	
ou, be executed ician and burial-transit	Exa	resulting in death) Last	Due to	(or as a consequ	uence of):								
6 / 6U, cate be executed shysician and the burial-transit	Ical	•	d									-	
Geath certificate attending physical dior use as the	/Med	IF FEMALE:	23c If yes out	come of pregna	IDCV						024 D-4	a af dalbu	
BO Beath c atten	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live b	ointh 2 ☐ Fetal	Ideath 3□	Ectopic pro					23d. Date Mor		Day Year
5 t t s	hysl	1 Yes 2 No 9 Unknown	9□ Unkn	own						,			
S, R es that igned b	by P	Part II. Other significant conditions	_		ulting in the u	nderlying ca	ause give	n in Part I	l.		_		he cause of death?
COLOS, A requires been sign should be	ted	Failure to Thriv	/e, Anem.	Ld				_		1 U Y	′es 2□No	3 Prob	pably 4 Nnknown
law r law r las be	Completed									24a. Was autop	sy p	Vere auto rior to co leath?	psy findings available mpletion of cause of
VITAI HEC sicien: The law certificate has b irector, page 2 s										1 ☐ Yes	2€ No 1		2□ No
OT VITAL Physicien: This certifica	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:		50/0		Othe			(Check only o			
- 2 SE	E	27. Manner of Death	101	of Injury th, Day Year)	28b. Time of		8c. Injury Work				dence 6 Othe		y)
r Attending er death.	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat		in, Day Fear)	Injury	M		/es 2 🗆	No				
IVIS	ertification;	3 Suicide 6 Could not determine	286. Place	of Injury - At ho	ome, farm, str	eet, factory	, office			28f. Location (S City or Tox		er or Rura	al Route Number,
Dital o	O												
DIVISION O To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Attent completely filled in by the funeral	edical	29a. Certifier 1 A Gertifying I (Check only one)	Physician: To the aminer: On the b and man	best of my kno asis of examina ner stated.	wieage, death tion and/or in	vestigation,	at the tim in my op	e, date an pinion, dea	nd place, ath occurr	and due to the ded at the time, of	cause(s) and ma date and place, a	nner as s and due to	the cause(s)
To the within To the	₩	29b. Signature and title of certifier				290		number			29d. Date signed		
+1								D5702	28		Decembe	r 29	, 2004
10,		30. Name and address of beison wh Aditya Chopra,			ely Av	enue,			nnapo	olis, MI	21401		
	tate	31. Date filed (Month, Day, Year)		Registrar's Signa	ture &	Spo	K	/					
Regis	trar	DEC 3 0 20	JU4 /A		/-	177							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death December Day 25, 200 4 **Physician** Jason 10:02AM Lee Keesee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Plata ar | If Under 9. Birthplace (State or Foreign 9395 Marcus Lane La I If Under 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** Days December. Months 214-19-2443 1**X** M 2□ F 24 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Macheal Franchiscoping. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 Yes 2 XNo Charles Completed by Funeral Director MD La Plata 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20646 9395 Marcus Lane USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give X Year or Dates: 1 Never Married 2 Married White 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steamfitter Union 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Willard L. Keesee, Jr. Cheryl Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cheryl Hall/Mother 12100 Charles St. La Plata, MD. 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) Brinsfield-Echols 12/30/04 20a. Method of Disposition 1 □ Burial 2 ② Cremation 3 □ Removal from State Charlotte Hall,MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00945 AREHART ECHOLS FUNERAL HOME, P.A. au P.O. BOX 567 LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 45pluxiA /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown leted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Comple autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Yes 2 No 2 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending thudin 10:0ZAM 1 ☐ Yes 2 🗖 No 12/25/04 investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 9395 Marcus Lane, La Plate 4 Homicide To the Hospital within 24 hours a To the Funeral E

MP 7 State

31. Date filed (Month, Day, Year) 2004

ylatria M.

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type. Print)
Yahia M. Tagouri, M.D. 11655 WineSapp Place, La Plata, MD 20646 32. Registrar's Signature

jagour.

Registrar

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0050883

MD

29d. Date signed (Month, Day, Year)

12/25/04

		1 - For State Registrar	State of M	aryland / [Depa		lealth and l	Mental Hygi		4 42860		
Physicia	90	Decedent's Name (First, Middle, ARLINE JUANITA						2. Date of Death Month DECEMBER	Day Ye			
/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, o	r Location of Deatl	h	4c. County of E	Death		
LAGITILI		CORSICA HILLS N	URSTNG HOME			CENTREV	TLLE		QUEEN	ANNE S		
Funeral				je (In yrs. last bir	thday)	If Under 1 Year	If Under 24 Hrs.			Birthplace (State or Foreign Country)		
Director		440-02-1905	1 ☐ M 2 🗶 F	63	Yrs.	Months Days	Hours Min.	SEPT. 1,		OUISIANA		
9		Usual Residence of Decedent										
nylan how		10a. State 10b. County		10c. City, Tow	n or Loc	ation				10d. Inside City Limits		
a-f.	cto	MD QUEEN	ANNE'S	STEVENS	SVIL	LE				1 ☐ Yes 2 X No		
th th or 26	Oire	10e. Street and Number				10f. Zip Code		10	g. Citizen of Wha	t Country?		
th wi	Funeral Director	103 DORCHESTER	ROAD			21666			USA			
ems ems	inei	11. Marital Status	12. Was Decedent Armed Forces?		13. W	as Decedent of H	lispanic Origin? (S an, Mexican, Puen	pecify Yes or No- to Rican, etc.)		American Indian, Vhite, etc.		
or it	F	1 Never Married 2 Marrie				☐Yes 2 X No	Specify:		Specify:	WHITE		
inal',	d by	3 Widowed 4 Divorced	Year or Dates:							WHITE		
72 h 'natu	ete	15. Decedent's (Specify only highest		16a.	(Give k	ent's Usual Occup and of work done	during most of wor	rking 1	6b. Kind of Busin	ess/Industry		
2 should be tiled within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "naturat", or Rems 23e or 28e-f show aumatic event, the Medical Examinar must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or			O NOT use retired	3)		OLDY HONE			
2 should be tiled within and Mental Hygiene. Is marked other than aumatic event, the Menmatic event.	To Be Cor	12 17. Father's Name (First, Middle, L.	acti	HC	MEM	AKER	19 Mothade Nar	ne (First, Middle, M	OWN HOME			
be ti			a5()						aloen Sumame)			
Mer Mark Mark		EDWARD TUSCH	(T Div)	4.01	4.4 - 121 -		UNKNOW		O' T O'-	7-0-41		
iges 1 and 2 should be tiled within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show it item 27 is marked other than "natural", or items and the notified at or other traumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationshi						ıral Route Number,				
permit. Pages 1 and 3 Department of Health Important: If item 27 eny injury or other tr. once.		JERRY G. LAY/HU	SBAND			ition (Name of	K KUAD,	STEVENSVI Date 2	DLLE, MU Oc. Location - City	21666		
Pages 1 nent of H ant: If ite arry or ot		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3	3 Removal from State	cemeter	ry, crem	atory or other plac	ce)	2	oc. Location - Git	y or rown, state		
permit. Pages Department of Important: If if eny injury or c		'4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		CHESAP		Name and Addre	ORY 12/2	7/2004	STEVENSV	ILLE, MD		
permit. Depart Import eny inj		23a. Part1. Enter the disease, or coshock, or heart failure. List o	complication, that caused	d the death. Do i	110	6 SHAMRO	CK ROAD,	CHESTER,	MD 216	Approximate Interval Between		
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	disease or condition resulting in death) Due to (or as a consequence of):									
te be executed ysician and te burial-transit	Examiner	Sequentially list conditions, if any, heading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
cate be e physician the buria	cai											
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending physicompletely tilled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Yes 0 Yes 2 Yes 0 Yes 12 Yes 0 Ye								delivery Day Year		
quires that in signed b uld be deta	þ	Part II. Other significant condition	ns contributing to death b	out not resulting in	n the un	derlying cause giv	ren in Part I.	1 ☐ Yes		te to the cause of death? Probably 4 Unknown		
The law re ate has bee page 2 sho	Completed							24a. Was an autopsy perform	ed? prior	e autopsy findings available to completion of cause of h? Yes 2 No		
ian: rtifica ctor, I	BeC	25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only one	/			
lysic direc	10	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	ent 2□ER/Ou	itpatient	3□ DOA Oth	ier: 45 Aursing H	lome 5 ☐ Resider	nce 6 Other (Specify)		
ending Ph sath. or: Atter th he funeral		27. Manner of Death 1 Satural 5 Pending 2 Accident investigs	ation		Time of Injury	28c. Injur Wor M 1	yat rk? Yes 2 □No	28d. Describe how	w injury occurred			
ital or Att irs atter di ral Direct led in by t	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Hornicide determin	building, e	jury - At home, fa tc. <i>(Specify)</i>				City or Town,	State)	r Rural Route Number,		
the Hosp in 24 hou the Funer ipletely til	fedical	(Check only 2 Medical E	Physician: To the best xaminer: On the basis of and manner st	of examination an		estigation, in my d	opinion, death occu	urred at the time, da	te and place, and	due to the cause(s)		
2 M T 0	Σ	29b. Signature and title of certified	mus	>		29c. Licens	3703 (d. Date signed (M	100 by		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Resistrar's Signature

			For Stete Registrar	State o	f Marylan		artmen rtificate			and M	lental Hyg	jiene leg. No.	004	42861
	Physicia	an l	1. Decedent's Name (First, Middle	e, Last)		т.	d b orre				2. Date of Dea Month	Day		
	/Medic	al	Rachel 4a. Facility Name (If not institution	a sing atract and pu	mberl		eibow:		Location o	of Death	Decemb	· -	County of Dea	
	Examin	er	Rockville Nurs:	_	111001)		AB. Ony,		cvill			40.		gomery
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under Months		If Under	_	8. Date of Birth	Year)	O. Di	rthplace (State or Foreign
	Director		125-38-5635	1 □ M 2 ☑ F	89	Yrs.	WOUTHIS	Days	110013	141111.	March 2	29,	1915 Ĭ	New York
	and	}	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits
	Maryl 1 sho	to	Maryland Monts	gomery		Rockv	i11e							1.∏Yes 2□No
	r 28a	Director	10e. Street and Number	503.027			10f. Zip	Code				10g. Citi	zen of What C	country?
	ith wit		213 Currier Dr	ive				20)850				ted St	
	tems	Funeral	11. Marital Status	Armed Fo		.S. 13.	Was Deced If Yes, spec	lent of Hi cify Cuba	spanic Ori n, Mexican	gin? (Spe 1, Puerto	ecify Yes or No- Rican, etc.)		 Race - Am Black, Whi 	
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	If Yes Gi	ve		1 ☐ Yes	2 ∑ No	Specify:				Specify:	white
21215-0036	2 hou	ted t	15, Deceder	t's Education		16a. Dece	dent's Usua	d Occupa	tion			16b. Ki	nd of Business	
215	thin 7.	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-4or 5+)	life.	kind of wo DO NOT us	nk done d se retired	unng mosi)	t of worki	ng			
2	ygien ygien rer th	Con	8			Purch	nasing	g Age		3. 81	(Final Adiation		edical	
and	ntal H ed otl	Be	17. Father's Name (First, Middle, Max	Levy					Le:		(First, Middle,			ainable)
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene, item 27 is marked other than "natural; or items 23a or 28a-1 show item 27 is marked other than "natural; or items 2a or 28a-1 show giher traumatic event, I've Medical Exercited Trains Legical Exercited Exe	2	19a. Informant's Name/Relations	The state of the s		19b. Maili	ng Address	(Street a			il Route Numbe			
S	nd 2 ; alth ar 27 is r trau		Sharon D. Hantı	nan, daus	ghter	213 (Currie	er Di	cive,	Roc	kville,	MD	20850	
ore,	of Head		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	2 M Romoval from		Place of Disponentery, crea	osition (Nar.	ne of ther place	9)		Date	20c. Lo	cation - City o	r Town, State
Ē	Pagment ant: h		'4 □Donation 5 □ Other (5		Ced				11111					New Jersey
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 ts any injury or other trau		21. Signature of Funeral Service	Litar	tteny	12/2-1	170 R	ockv:	ille :	Pike	Memoria , Rockv	i11e		Inc. 20852
П			23a. Part1. Enter the disease, o shock, or heart failure. List	complications that only one cause on	caused the seat each line.	th. Do not en	ter the mod	e of dying	g, such as	cardiac o	or respiratory are	rest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	d	HEMIC BO									WEEKS
	Examiner		,		or as a consec ARDERATI		TTNAT	пери	JTA					WEEKS
		Jer	Sequentially list conditions, if any, leading to immediate		(OF BE B GUNSHO		JINAL	IILKI	IIA					WLLIND
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С										
, 0,	cate be executed physician and the burial-transit	I Ex	resulting in death) Last	Due to	(or as a consec	quence of):								
8760,	cate b	dical		d										14 T
9 X	that the death certifics ed by the attending pt detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		itcome of pregn								23d. Date of de	elivery
Вох	death a atter d for L	iciar	in the past 12 months?	4□Preg	birth 2 🗌 Feta nant at time of c		⊒Ectopic pr ⊒ Other (sp						Month	Day Year
P.O.	tt the c by the tacher	hys	9 Unknown	9□ Unkr	nown						T			
	res that the de signed by the a be detached t	by F	Part II. Other significant conditi	ons contributing to c		-	ınderlying c	ause give	en in Part I.					to the cause of death? Probably 4 XDUnknown
ecords,	law requires as been sign 2 should be	ted	CKIII	CAL AUKII	SIENO	313					-		1	
3ec	9 2 9	Completed									24a. Was a autop perfor	sy	24b. Were a prior to death?	autopsy findings available completion of cause of
al B	ician: The l certificate ha ector, page	e Co	25. Was case referred to medica						OC Diese	of Dooth		2X No	1 □ Ye	
Vital	Physician: r this certific ral director.	0 8	examiner? 1 Yes 2X No	Hospital:	Inpatient 2] ER/Outpatie	nt 3 DC	Othe			me 5 ☐ Resid		6 □Other (Sp	ecify)
J Of		T :u	27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o	of 2	8c. Injury Work			28d. Describe h			
sior	Attending r death. sctor: After	atlc	Z [] / tooldoilt	igation			М		Yes 2					
Division		ertification;	3 Suicide 6 Could 4 Homicide determ	nined 288. Plac	e of Injury - At h ling, etc. <i>(Speci</i>		reet, factor	, office			28f. Location (S City or Tow	itreet an m, State	d Number or F)	Rural Route Number,
	Hospital 4 hours a Funeral I	O	29a. Certifier 1X Certifyi	ng Physician: To th	e best of my kn	owledge, deal	th occurred	at the tim	ne. date an	nd place.	and due to the o	ause(s)	and manner a	as stated.
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	(Check only 2 Medicel one)	Exeminer: On the I	pasis of examination	ation and/or in	vestigation	, in my or	oinion, dea	th occurr	ed at the time, o	date and	place, and du	e to the cause(s)
	To the l within 2. To the I complet	Me	29b. Signature and title of certific	er 📄	0		290	c. License	number		2	29d. Dat	e signed (Mon	nth, Day, Year)
)	4		1	~1/5	an ,			D20	0148			DECE	MBER 2	9, 2004
	/		30. Name and address of person											
	Sta	ato.	STEVEN DOLINSK 31. Date filed (Month, Day, Year	Y, M.D.,	Registrar's Sign	ature	VENUE	, GA	LIHEK	υσυκ	G, MAKY	LAND	2087	/
à.	Regist		JAN 0 3	3 2005	Registrar's Sign	5 A	are of							

			State of Maryland / Depar		-	-					
			1- Stete Registrer Certif	ficate of Death		Reg. No.	42862				
	Physici	an	1. Decedent's Name <i>(First, Middle, Last)</i> John Guy Lane, Jr.		2. Date of Dea	Day Year	3. Time of Death 01:08A M				
	/Media	cal		4b. City, Town, or Location of Death	Decembe	r 31, 2004					
	Examir	ier		Frederick		Frederi					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Wonths Days Hours Min.	8. Date of Birt		hplace (State or Foreign				
	Director		578-12-5431 1XM 2 F 81 Yrs.	violitis Days Hours Will.	8. Date of Birt (Month, Da July 14	, 1923 Wash	ington, D.C.				
	yland how		10a. State 10b. County 10c. City, Town or Loca	tion			10d. Inside City Limits				
	e Mar	ctor	Maryland Frederick Frederick				1 ☐ Yes 2 ☐ No				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumetic event, the Medical Examinational be invitible at ance.	Completed by Funeral Director	10e. Street and Number 9222 Opossumtown Pike	10f. Zip Code 21702		10g. Citizen of What Co U.S.A.	ountry?				
	ems	Iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 19. Was Decedent Ever in	s Decedent of Hispanic Origin? (Sp 'es, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whit					
36	s afte	y FL	1 Never Married 2 Married 1 7 Yes 2 No	Yes 21 No Specify:	, , , , ,	Specify:					
21215-0036	tural	edb	15. Decedent's Education 16a, Deceder	nt's Usual Occupation	1	16b. Kind of Business/	hite Industry				
215	nin 72 In ne Medis	plet	(Specify only highest grade completed) (Give kir Elementary/Secondary (0-12) College (1-4or 5+)	nd of work done during most of work) NOT use retired)	ring	Washington					
21	ad with	Com	12 Service	eman		Light Compa	iny				
nd	be filk tal Hy d oth	Be	17. Father's Name (First, Middle, Last)			Maiden Sumame)					
<u>\S</u>	d Men narke	To.	John Guy Lane, Sr.		otte Ma		7 0 11				
Maryland	id 2 sh Ith and 27 is n treun			Address <i>(Street and Number or Rur</i> Dpossumtown Pike,							
ē,	f Heal		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition cemetery, cremai	ion (Name of	Date	20c. Location - City or	Town, State				
Ë	Page nent o nt: If		1 □ Burial 2 ☑ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Frederick 0		2005	Frederick,	Maryland				
Baltimore,	permit. Departn Importe any inju			The state of the s	-	Funeral Hom					
	90 E # 9			21 Opossumtown Pi			yland 21702				
		-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death				
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Myocardial Inf	erchion							
	Examiner		Due to (or as a consequence of): Angle Act.								
		ner	Sequentially list conditions								
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
760,	te be executed ysician and te burial-transit	cai Ex	Due to (or as a consequence of):								
687		edica	d.	_							
Box (n certif	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	ivery				
	death	Physician/M	in the past 12 months? 1 Yes 2 No 1 Ves 2 No	etopic pregnancy other (specify)		Month	Day Year				
P.0	at the 1 by th stach	Phys	9 Li Onknown		1						
Records,	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	by	Part II. Other significant conditions contributing to death but not resulting in the under Mitral Valve Regissionship	erlying cause given in Part I.	23e. Did to	bacco use contribute to es 2 ⊡No 3 □ Pro	the cause of death? bbably 4 Dunknown				
eco	law requir as been si 2 should I	Completed	Bicuspid Aortiz Valve		24a. Was autop		topsy findings available				
E B		Соп	total colections		perfor	med? death?	2 No				
Vital	ysician: is certific director,	Be	25. Was case referred to medical Vexaminer?	26. Place of Deat							
of	Phys	To ::	1 ☐ Yes 2 ☐ No	4 Nursing Ho		ence 6 Other (Spec	cify)				
On	Attending Physician: r death. ector; After this certific by the funeral director,	ation	1 12 Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		,,					
Division	l or Attendi after death. Director: A I in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	t, factory, office	28f. Location (S City or Tow	treet and Number or Ru	ral Route Number,				
O	ital or rs afte ral Dir led in		Dullying, vie. (appeary)		Olly or Tow	n, siale)					
	To the Hospital or Attendwithin 24 hours after death To the Funeral Director;	Medicai	29a. Certifier (Chack only one) Chack only one) 1 ★ Certifying Physician: To the best of my knowledge, death or characteristics of examination and/or investigation and manner stated.	ccurred at the time, date and place, stigation, in my opinion, death occur	and due to the ored at the time, o	ause(s) and manner as date and place, and due	stated. to the cause(s)				
	To the within To the	Me	29b. Signature and title of centilis	29c. License number	2	29d. Date signed (Month	n, Day, Year)				
			· Ku	D005088	30	1-3-2	005				
	(3)		30. Name and a ress of person who completed cause of death (Item 23a) (Type, Pri N. David 7204 MD 56 TJ Orive	, may	mo	21702					
	* Sta		31. Date filed (Month, Pays Year) 1 2005 32. Registrar's Signature	coll s	-						
	Registi	al	Note that the last th								

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Ma	aryland	d / Depa	artment of H rtificate of L	ealth a	and M		giene () 4	428	63
	0		1. Decedent's Name (First, Middle, La	st)				-		2. Date of Dea Month	ath Day	Year	3. Time of	
	Physici /Medio		Mary	Larso	on						er 30 2	2004	9:00	_рм_
	Examin		4a. Facility Name (If not institution, giv				4b. City, Town, or		of Death			y of Death		
			Heart Homes Assis				Odenton	∩ If Under 2	Od Uro T			e Arı		
	Funeral		5. Social Security Number 6. S	ex 7. Ag □M 2521F	e (in yrs. i 78	ast birthday) Yrs.	Months Days	Hours	Min.	8. Date of Birt (Month, Day	v, Year)	Cou		r Foreign
	Director		119–16–0762 Usual Residence of Decedent	21	70					July 5,	. 1926	New	York	
	ow ow		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside Cit	y Limits
	Many Fed	ţō	MD Anne Ara	ındel			Odento	n					1 🗌 Yes	2 X No
	r 288	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cou	ntry?	
	th wit	ai D	8735 Piney Orchai	d Parkway			21113				USA	Δ		
	dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Orig	gin? (Spe	cify Yes or No-	14. Ra	ce - Ameri	can Indian,	
36	or It	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 📉 I If Yes, Give	No	1		Specify:			Speci	6		
8	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show dical Examinar must be notified at	d by	3 X Widowed 4 □ Divorced	Year or Dates:	57	10.0				20		, MI	nite	
215-0036	n 72 nat	lete	15. Decedent's E (Specify only highest gr	ade completed)		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	turina most	t of workii	ng	16b. Kind of E	susiness/in	ioustry	
212	within lene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		ress	,			resta	urant	-	
	Hyg other	a	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle,	Maiden Suma			
<u>a</u>	Ald be Aenta rked tic av	To B	Carl	Vizine				Ida	a		Vitel	.lo		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. Itam 27 Is marked other than *natural; or itams 23e or 28e-f show than traumatic avant. Its Medical Examinar must be notified at		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street a	and Numbe	r or Rura	l Route Numbe	r, City or Town	, State, Zip	Code)	
	1 and 2 Health am 27 I		James E. Larson,	son			Cox Rd.,	Ches				20732		
ore	it of He if itar		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Removal from State	20b. P	lace of Dispo emetery, crei	sition (Name of matory or other plac	θ)	D	ate	20c. Location	- City or To	own, State	
Ĕ	Pag ment ant:		`4 ☐ Donation 5 ☐ Other (Speci	y)	Met		itan Crema			31–04	Alexan	dria	, VA	
Baltimore,	permit. Pages 1 and Department of Healt Important: If itam 2 any injury or other 2006.		21. Signature of Funeral Service Lice	R. Her	~		2. Name and Addres Rausch Fur			e, P.A.	, Owin	gs, <u>N</u>	1D 2073	6
I	Physician		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that of used one cause seach li	d the death ne.	n. Do not ent	er the mode of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Betwoonset and D	veen
	/Medical Examiner		resulting in dealth)	Due to (or as	a consequ	uence of):	dem	nnt	ia				UPC	2
		Je.	Sequentially list conditions, a any, leading to lamin solute cause. Enter Underlying Cause (Disease or injury	b. Die to (or as	a consequ	iunea of)	aem	11	10(- 14	y car	
	and L-transit	Examiner	Cause (Disease or injury that initiated events	c										
O,	be executed sician and burial-transit		resulting in death) Last	Due to (or as	a consequ	uence of):								
8760	ys e	licai		_ d										
9	seath certificate attending phys of for use as the	/Med	IF FEMALE:	23c. If yes, outcome	of pregna	nev								
Box	death c e attend ad for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal	Ideath 3	Ectopic pregnancy Other (specify)				T.	ate of deliv onth		'ear
0	0 0 0	ysic	1 ☐ Yes 2 🖫 No 9 ☐ Unknown	9□ Unknown	t time or de	50,11								
Ω.	requires that the een signed by th nould be detache		Part II. Other significant conditions	contributing to death b	out not resu	ulting in the u	nderlying cause give	en in Part I.		23e. Did to	obacco use cor	tribute to t	he cause of d	eath?
Vital Records,	quires n sign ald be	Completed by	Chronic Ob.	structiv	e M	ulmo	nary c	Dis	Cas	e_ 101	′es 2□No	3 🗌 Prol	bably 4 🖽	nknown
00	> 0 70	olete					-)			24a. Was	an 24b.	Were auto	opsy findings a empletion of ca	available
Re	o <u> </u>	mo									rmed?	death?	mpletion of ca 2□ No	luse of
ta	ician: Th certificate rector, pag	a l	25. Was case referred to-medical					26. Place	of Death	(Check only o		1 1	Assite	d
	d is	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗆 Inpatie	ent 2	ER/Outpatier	nt 3 DOA Othe	er: 4 □ Nu	rsing Hor	me 5□Resid	dence 6 Dt	her (Speci	y) livii	19
n o	Jing Pho		27. Mann of Death 1 Matural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry iy Year)	28b. Time o Injury	Work			28d. Describe h	now injury occu	rred	2	
sio	aath be:	cati	2 Accident investigation 3 Suicide 6 Could not to					Yes 2□					10 . 11	
Division of	l or Atten after deat Diractor:	Certification:	4 Homicide determined		jury · At ho tc. <i>(Specif</i>)	ome, tarm, st v)	reet, factory, office		1 1	City or Tox	Street and Num vn, State)	per or Hun	ai Houte Numi	per,
	Hospitel 4 hours a Funaral E	S	29a. Certifier 1 Certifying P	typicing. To the best	of my kno	wladaa daat	h annumed at the time	an data an	d plane	and due to the	nauco(s) and m	20001 20 1	rtated	
	To the Hospitel or Att within 24 hours after de To tha Funaral Diract completely filled in by the	edicai		nysician: To the best miner: On the basis o and manner st	of examinat									
	To the within 2 To tha comple	Me	29b. Signature and title of certifier				29c. License	e number			29d. Date sign	ed (Month,	Day, Year)	1
	- S - O				1	- n	11)	50-	729	5	12-	31	- <i>ac</i>	64
	4		30. Name and address of person who	completed cause of o	death (Item	1 23a) (Type,	Print)	. 1	. 11		, /			,
	6		Jenniter Kied	nger 86	01 V	etero	Print) D	Mi	lle	rsv.C	le,/	VID	21	108
• <		ate	31. Date filed (Month, Day, Year)	32. Registr	ra s Signa	ture								
	Regist	al	עחוז (O COOL	MEGLAS	I St.	Charles !							

	-	For Stete	State of Mary	•	artment of F		nd Mental Hy	giene Reg. No. 200	4 42864
		Registrer 1. Decedent's Name (First, Middle, Last)		timouto or	D Outin	2. Date of De	eath	3. Time of Death
Physicia		MARY	S. LEWIS	S			DECEMB		04 2:05 A M
/Medic Examin		4a. Facility Name (If not institution, give		J	4b. City, Town, o	or Location of		4c. County of	
LXdiiiii	Ç.	3326 TIDEWATER CO			OLNEY			ТИОМ	GOMERY
Funeral		Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bi		Birthplece (State or Foreign Country)
Director		537 20 6981	M 212√F 8	33 Yrs.	Months Days	Hours	July	28 1921	Connecticut
D.		Usual Residence of Decedent	100	Ch. Town					404 Lesiste City Limite
show	_	Md. 10b. County Md. Montgol		c. City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🔊 No
the Ma	Director		ile i y	OTHEY	1			40 000 100	
uth with the Maryla 23a or 28a-f shoi ust be notified at	늠	10e. Street and Number			10f. Zip Code	200		10g. Citizen of Wha	•
ath w	rai	3326 Tidewater C	DUPT 12. Was Decedent Ever	in 11 C 40	208		-2 (Specific Ven es N	United S	American Indian,
Items	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	III U.S. 13.	Il Yes, specify Cub	an, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	Black,	White, etc.
irs af	by	3 ★ Widowed 4 Divorced	If Yes, Give Year or Dates:		1□ Yes 2⊠ No	Specify:		Specify:	White
be filed within 72 hours after death with the Maryland tal Hygiene. All Hygiene. The Maclical Exercities I was be notified at sevent, It a Maclical Exercities I was be notified.		15. Decedent's Ed		16a. Dece	dent's Usual Occup	pation		16b. Kind of Busin	ness/Industry
hin 7.	Completed	(Specify only highest grad	College (1-4or 5+)	life.	kind of work done DO NOT use retire	dunng most o	or working		
d with giene	E O	12	3	No.	urse			Public	Health
al Hy roth	Be (17. Father's Name (First, Middle, Last)				7.	s Name (First, Middle		
Menti Menti	2	Charles Peter	Sharkey			Mar	<u> </u>		
2 should and Men is marks		19a. Informant's Name/Relationship (7			•		or Rural Route Numi		
and lealth m 27		Candy West / Dau					, Caldwel	20c. Location - Ci	33, 3, 33
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Item 100ce.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	nemoval from State		osition (Name of matory or other pla				
tmen tant:		`4 □Donation 5 □ Other (Specify			itan Crem		2/29/04		dria, Va.
permit. Departr Imports any Inju		21. Signature of Funeral Service Licen:	Bark	2/ 2			er Funera		
40200		23a. Part 1, Enter the disease, or comp	lications that caused the	death. Do not on			8, Layton		1. 20882 Approximate
		shock, or heart failure. List only of	one cause on each line.			_	•		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a		derehoe 1	(ماسه	rocy Disco	٥ د	15 years
Examiner			Due to (or as a co	nsequence of):					
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uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
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ate be	dicai	(d						
ntifica ng ph	Med	IF FEMALE:							
leath certifics attending pt	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 Live birth 2 □	Fetal death 3	⊒Ectopic pregnand	у		23d. Date of Month	
the all	Physician/Me	1 Yes 2 No	4□Pregnant at time 9□Unknown	e of death 5	Other (specify)				,
hat the deby	_	Part II. Other significent conditions of	ontributing to death but no	ot resulting in the	underlying cause of	ven in Part I.	23e. Did	tobacco use contrib	ute to the cause of death?
signe d be	d by			J			182	Yes 2□No 3	☐ Probably 4 ☐Unknown
requestion of the second	etec						24a. Wa	s an 24h We	re autopsy findings available
has ge 2	Completed						auto per	opsy prio	or to completion of cause of ath?
n: Th	e Co	25. Was case referred to medical				OF Place	1 ☐ Yes ol Death (Check only		Yes 2 No
sicia s certi	To Be	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 DOA Ot	hor	sing Home 5 PRes		(Specify)
eral o		27. Manner of Death	28a. Date of Injury (Month, Day Ye					how injury occurred	
ath. r: Afte e fune	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		ar) Injury		Yes 2□N	0		
Afte ar deir decto	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, si	reet, factory, office			(Street and Number	or Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:								
Hospl 4 hou uner		(Check only 2 Medical Exam	ysicien: To the best of m	amination and/or it					
the hin 24	Medical	one)	and manner stated.			se number		29d. Date signed (
J Wit	-	29b. Signature and title of certifier				-	,		
10/5)	guen	mo	//		2457		Welling	15 29, 2024
		30. Name and addless of person who	completed cause of death	To L Co	Printy A. Le	alheat	. 100 1		
Sta	ato	31. Date liled (Month, Day, Year)	32. Registrar's	Signature 🗡)1000	-01.047	on, or a		
Sta Registi		DEC 30 20	MA Sener	2	spork	2			

			1 = For Stete Registrar	State of Marylar		artment of I		d Mental Hy	giene Reg. No.	004	42865
			Decedent's Name (First, Middle, Las	ıt)				2. Date of De		Year	3. Time of Death
	Physici /Medio		Alma Odila Larim	ore				Decembe		, 2004	10:40 A M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of D	Death		County of Death	
			1610 West Pulask 5. Social Security Number 6. Se		last hirthday	E1kton If Under 1 Year	If Under 24	Hrs. 8. Date of Bir		cil O Right	place (State or Foreign
	Funeral Director			☐ M 2 🖾 F	83 Yrs.	Months Days		Win. (Month, Da	ıy, Year)	Cou	ntry) Virginia
	D D		Usual Residence of Decedent			l		JULY 17	9174.		
	show	_	10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2 💆 No
	8a-f	Directo	Maryland Cecil	E1	Lkton	1					
	with t	<u>i</u>	10e. Street and Number			10f. Zip Code				en of What Cou	,
	leath	Funeral	1610 West Pulaski	12. Was Decedent Ever in U	J.S. 13.	21921 Was Decedent of I	Hispanic Origin			ed State 4. Race - Ameri	
0	or Iten		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2X No	i			? (Specify Yes or No luerto Rican, etc.)		Black, White,	
<u>ල</u>	ours a	d by	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:			Specify: Wh	ite
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. id other then "naturel", or items 23e or 28e-f show event, I'v. Medical Examinat must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup kind of work done	during most of	working	16b. Kin	d of Business/In	ndustry
121	within ane. then	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	•		_		
2	filed Hygie other	Co	12 17. Father's Name (First, Middle, Last)		Resta	urant Ow		Name (First, Middle		l Servic _{Sumame)}	:e
<u>a</u>	should be filed within a Mental Hygiene. marked other then imatic event, ID-M	To Be	George Edward Cati	lett			Lillia	n Ruth Da	nner		
ary	2 should and Men Is marke aumatic	-	19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Street		r Rural Route Numb		Town, State, Zij	code)
Ž	is 1 and 2 should by Health and Men item 27 is marke other traumatic		Charles Pennington	ı,Sr./Son	_48 Hi	ckory Dr	ive,Nor	th East,M	ary1a	and 2190	1
Baltimore,	00 0		20a. Method of Disposition 1 Burial 2 Cremation 3	Romoval from State	cemetery, cre	osition (Name of matory or other pla		Date		cation - City or T	
Ĕ	Pa men ury		`4 □ Donation 5 □ Other (Specify) 2		t Method tery		nyary 4,	North	ı East,M	aryland
3all	permit. Pag Department Important: eny injury c		21. Signature of Fundad Service Liven			2. Name and Addre		Crouch Fu			
	a0280		23a. Part1. Enter the disease, or comp	W				reet,Nort		st,Mary1	and 21901 Approximate
			shock, or heart failure. List only	one cause on each line.			ng, such as car	diac or respiratory a	rrest,		Interval Between Onset and Death
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	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c CANCET	2 OF	ME	Lunc	55			3 4DAMS
oʻ	ate be executed hysician and the burial-transit	Ex	resulting in death) Last	Due to (or as a consec	quence of):						
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9 ×	death certific e attending pl id for use as t		IF FEMALE:	23c. If yes, outcome of pregna	ancy						
Вох	attene for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Feta	aldeath 3[Ectopic pregnanc Other (specify)	у		2	3d. Date of deliv Month	ery Da y Year
o.		ysle	1 ☐ Yes 2 ØNo 9 ☐ Unknown	9 Unknown							
o.	The law requires that the te has been signed by this page 2 should be detache	by Pr	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did t	obacco us	se contribute to t	he cause of death?
Records,	w require been sig should b							11	Yes 2 🗷	No 3□ Prot	oably 4 Unknown
000	e law re has bee je 2 sho	piet						24a. Was		24b. Were auto	ppsy findings available impletion of cause of
		Completed						perfo	rmed? 2 No	death?	
Vital	Attending Physicien: Thir death. ector: After this certificate by the funeral director, pag	Be (25. Was case referred to medical examiner?	11		112.		Death (Check only o	ne)		
of	Physi this c	T.	1 Yes 2 No	Hospital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Input 28a. Date of Injury	ER/Outpatier	11 30 DOX		ng Home 5 President			(y)
בס	ding h. h. After funer	tion	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	rk?]Yes 2 ∐No	28d. Describe	now injury	occurred	
Division	or Atteno after death Director: in by the	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At h	iome, farm, sti		, , , , , , , , , , , , , , , , , , , ,	28f. Location (Street and	Number or Rura	al Route Number,
2	in Dir	erti	4 Homicide determined	building, etc. (Special	fy)			City or To	νπ, State)		
	To the Hospitel or within 24 hours afte To the Funeral Direct completely filled in It		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	owledge, deat	h occurred at the ti	me, date and p	lace, and due to the	cause(s) a	and manner as s	tated.
	To the Hos within 24 h To the Fun completely	edicai	one)	niner: On the basis of examina and manner stated.	ation and/or in			occurred at the time,			
	To t To 1	Σ	29b. Signature and title of certifier	* 0		29c. Licens				signed (Month,	
			- alundal	Enjoule		000	1463		1-8	5-05	116-2-
	6		30. Name and address of person who	completed cause of death (Iter	m 23a) (Туре,	Print)	14	1-15	/	000	21921 NM
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	178 6	1 wed	14101	- 6	CKN	U MI
	Registr		IAN 3 - 2005	way & A	parti						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Marylan		artment of H rtificate of L			ene 004	42866
	Dhysisi		1. Decedent's Name (First, Middle, Last)					2. Date of Death	h Day Yeer	3. Time of Death
	Physici /Medic		Edna C. Linthica	ım				Dec.	24, 2004	1 10:30 a ^M
7	Examin	er	4e. Fecility Name (If not institution, give s				Location of Deeth		4c. County of Dee	
			462 Arundel Beac 5. Social Security Number 6. Sex		last hirthday)	Several Severa	erna Park		Anne Ar	
	Funeral Director			M 2XIF 86	Yrs.	Months Days	Hours Min.	8 Date of Birth (Month, Day, Jul. 27,	1918	rthplece (Stete or Foreign country)
	ow #		10a. State 10b. County		y, Town or Lo					10d. Inside City Limits
	Many First	ţo	MD Anne Aru	ndel	2	Severna P	ark			1 ☐ Yes 2 ŽNo
	n with the	i Direc	10e. Street and Number 462 Arundel Beach	Road		10f. Zip Code 2114	6	10	Og. Cilizen of What C US.	-
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 Ie marked other than "natural", or Items 23a or 28a-f ehow or other traumatic event, the Medical Examinar must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 25 No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	hours tural'	ed b	3 Widowed 4 Divorced	Year or Dates:	16a Decer	dent's Usual Occupa	ation		16b. Kind of Business	Andustry
15	n ne	piet	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	during most of work	ing	TOD. KING OF BUSINESS	williastry
212	d with giene	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Tea	acher/Pri	ncipal		Education	on
	2 should be filed within and Mental Hygiene. Ie marked other than raumatic event, the Me	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, N	Maiden Sumame)	
yla	should b and Ment marked umatic e	Tol	Luther Cartwright	<u> </u>			Edna Han	mond		
Maryland	2 short and and le m		19a. Informant's Name/Relationship (Ty)						City or Town, State,	
	1 and Health em 27 ther t		Robert C. Linthic 20a. Method of Disposition			Arundel I			ma Park, 1	
Baltimore,	4 Donation 5 Other (Specify)								Glen Burn	•
Ball	Departimonal Importantial		21. Signalure of Funeral Service License	Sons, P. itchie Hw	A. Sever	na Park Fi na Park, I	uneral Home MD 21146			
Р			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death re cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CEREBR	10 VI	9 scur	AR D.	ISEAN	pa h	Onset and Death
	/Medical Examiner		resulling in death)	Due to (or as a consequ	uence of):					
		7	Sequentially list conditions,	Due to (or as a consequ	uence of):					
	nted I Insit	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ć,	execu in and ial-tra	Examiner	resulting in death) Last	Due to (or as a consequ	uence of):					
68760,	ysicia ysicia	edicai		l						
	ng ph		IE ECMAN E							
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	l ivery Day Year
α.	s that ned b e deta	by Pi	Part II. Other significant conditions con	tributing to death but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
rds	w requires been sign should be	ed b						1 □ Ye	s 2 □ 46 3 □ P	robably 4 Dunknown
Records,	sician: The law re certificate has ber irector, page 2 sho	Completed						24e. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
of Vital		Bec	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one		
) V	hysic his ce Il dire	_C	1 □ Yes 2 □ Mo	ospital: 1 Inpatient 2			4		nce 6 Other (Spe	ocify)
Division o	fing After fune	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	Work	rat t? Yes 2 □No	28d. Describe hov	w injury occurred	
Divis	tal or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (29a. Certifier (Check only one) Continue Check only (Check only one)	sician: To the best of my knower: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the time restigation, in my op	e, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and menner as te and place, and due	s stated. e to the cause(s)
	To t To tl	Σ	29b. Signature and title of certifier	MD		29c. License	57531		d. Date signed (Mont	· ·
			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type.	Drint)				
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 9	32. Registrar's Signal	ture	berte				

			For State Registrar	State of M		Depa	artment of H	ealth a	and Me	ental Hyg	_) 4	42867
			Decedent's Name (First, Middle, Last	st)						2. Date of Dea Month	th	Year	3. Time of Death
	Physici /Medic		HANNAH	E	MAC	CCOR	MACK		D	ECEMBER	Day 2	004	10:55 P M
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, or		of Death			y of Death	
		4	CHERRY LANE NURS 5. Social Security Number 6. S		R ge (In yrs. last bi	irthdav)	LAUREI		24 Hrs.	8. Date of Birth			EORGE S
	Funeral Director			_M 2⊠F	91	Yrs.	Months Days	Hours		May 24	1913		place (State or Foreign Intry) Ca Leone Wi
	<u> </u>		Usual Residence of Decedent										
	arylar ehow	_	MD Prince G	orge!s	10c. City, Tov		Park						10d. Inside City Limits 10d. Inside City Limits 10d. Inside City Limits
	The M	ecto	10e. Street and Number				10f. Zip Code				0g. Citizen of	What Cou	
	with with with	ä	5004 Geronimo St	reet			20740			'	U.S.A.		,
	death	nera	11. Marital Status	12. Was Deceden	t Ever in U.S.	13.	Was Decedent of Hi f Yes, specify Cuba	spanic Ori	igin? (Spec	cify Yes or No-	14. Ra	ce - Ameri	can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f ehow importent: If item 27 is marked other the "mortified Esara" or other treumetic event. I've Medical Esara" or must be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 Yes 2 K If Yes, Give Year or Dates:	No		1 □ Yes 2⊠ No	Specify:		noan, etc.)	Speci	6	lack
21215-0036	2 hou	ed	15. Decedent's Ed	lucation		a. Dece	dent's Usual Occupa	ation		I	16b. Kind of E		
215	hin 72 9. 9n "na Medi	plei	(Specify only highest gra	de completed) College (1-4or	5+)	(Give life.	kind of work done of DO NOT use retired	luring mos)	t of workin	g			
N	filed wit Hygiene Sther the ent. I'm	Con		2+]	eacher				Govern		
nd	be file	Be	17. Father's Name (First, Middle, Last)						er's Name 10da	(First, Middle,	Maiden Suma	me)	
Maryland	2 should be filed within and Mental Hygiene. Is marked other then beumatic event. It a Me	ပ္	Sylvester Sav	yerr	10	lb Mailie	ng Address (Street a			Jones	. Ciby or Tour	State 7	a Codo)
Mai	d 2 sh th and th and 7 ls m treum		Egerton Maccormac	* .							-		and 20740
ē,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tree		20a. Method of Disposition		a a a a a a a a	of Dispo	sition (Name of natory or other place	o)	Da	ate	20c. Location	- City or T	own, State
E O	Page:		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		9	-	ashington		1/15/	05	Ade1ph	i,Mar	yland
Baltimore,	permit. Departm Departm Importe any inju		21. Signature of Funeral Service Licer	IS00	1	_	. Name and Addres			B. Jenk			
m	8 8 E 8		6 6			7	474 Lando	ver I					
760,	Physician / Medical Examiner pontion and purial-transit the pnital-transit the pnital-transit physician and pnital-transit physician and physician and physician and physician p	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, isading to finite clate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CO Jua to (or s	s consequence	a offy) [ear	<i>A</i>	Fa.	lun		
P.O. Box 68	that the death certificate bed by the attending physic detached for use as the b	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal deat at time of death		Ectopic pregnancy Other (specify)	-		no lit	1	ate of delivionth	very Day Year
	S L e	d by Pt	Part II. Other significant conditions of	contributing to death	but not resulting	in the u	nderlying cause give	en in Part I	l.	23e. Did to			the cause of death?
COL	w require been sig should b	Completed								24a. Was a	ın 24b.	. Were aut	opsy findings available
Re	The law ate has b page 2 st	dwc								autop:	SV I	prior to co death? 1 \(\text{Yes}	ompletion of cause of
tal		a	25. Was case referred to medical					26. Place	e of Death	(Check only or		103	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division of Vital Records,	this aldii	1: To B	examiner? 1 Yes 2 No 27. Mannar of Death	Hospital: 1 ☐ Inpate 28a. Date of In	jury 28b.	. Time o	f 28c. Injury	4 ≥ Ni ⁄at		ne 5 🗆 Resid 8d. Describe h			ify)
lon	nding f th. :: After e funer	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, E	Day Year)	Injury	Worl M 1□	k? Yes 2□	No				
)ivisi	or Attendiater death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be determined	286. Place of I	njury - At home, etc. (Specify)	farm, st	reet, factory, office		2	8f. Location (S City or Tow	treet and Num n, State)	ber or Rur	al Route Number,
1	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical Ce		nysician: To the bes miner: On the basis and manner:	of examination a								
	To the within 2 To the comple	Me	29b. Signature and title of certifier	and manner :	stated.		29c. License	e number		_ 2	29d. Daye sign	ed (Month,	, Day, Year)
	F 3 F 8		1) munt	The	0		005	32	35		1/3/	05	
e	(5)		30 Name and address of person who	completed cause of	death (Item 23a	Type.	1		- /	Ara	1011		20707
			31. Date filed (Month, Day, Year)	32. Regis	strar's Signature	1-10	1/1/m	ne	/	100.	- Cul	ry	000/
	St Regist	ate rar	IAN 0 4 2005	Break	K A	234	u						

DHMH 17 Rev 1/2001

		-	1 - For State of Maryland / I	Department of Health and M Certificate of Death		0001 1000		
	Physici /Medic		Decedent's Name (First, Middle, Last) MILDRED McRAE		2. Date of Death Month D 12	3. Time of Death P 80 04 6:12		
	Examin		4a. Facility Name (If not institution, give street and number) SOUTHERN MD. HOSPITAL CENTER	4b. City, Town, or Location of Death Clinton, Md	P	Date of Death Month 2ay 79 3. Time of Death Month 2ay 79 4. County of Death Prince George's Date of Birth (Month, Day, 79 1) 192 2 Maxton, N. anuary 9, 192		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last bit</i> 82	rthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea, January 9,	9. Birthplace (State or Foreign Country) Maxton, N.		
	ith the Maryland or 28a-f show	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow Md Prince George's 0xon	Hi11		10d. Inside City Limits 11 Yes 2 □ No		
	3a or 2	i Dire	2302 Norlinda Ave.,	10f. Zip Code 20745				
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If itam 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Evantine must be troitled at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 X Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	Black, White, etc.		
21215-0036	filed within 72 hou Hygiene. Ithar than "natura int, the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of worki life. DO NOT use retired) Nurse	ing			
Maryland 2	2 should be filed withir and Mental Hygiene. is marked other than aumatic evant, the Ma	To Be Co	17. Father's Name (First, Middle, Last) Dave Leggett		e (First, Middle, Maide			
Mary	12 should h and Men 7 is marke traumatic							
Baltimore,	Pages 1 and lent of Health nt: If itam 27 ry or othar tr		20a. Method of Disposition · 20b. Place of cemeter cemeters and Particle 1 Property of the cemeter cemeter cemeter cemeter cemeter cemeters.	302 Norlinda Ave., Oxo of Disposition (Name of ory, crematory or other place) ny Memorial Park 1-5-0	Date 20c.	Location - City or Town, State		
Balti	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service Ucensee	22. Name and Address of Facility 1 425 Maryland Ave.				
	Physician /Medical Examiner		23a. Pant 1. Enter the disease or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence	not enter the prode of dying, such as cardiac of Newmona of: Office of the product of the prod	or respiratory arrest,	Approximate Interval Between		
8760,	cate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence consequence consequence) c. Due to (or as a consequence consequence)	/	menle	71547		
.O. Box 68	death certific e attending p ed for use as	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	h 3 DEctopic pregnancy 5 Other (specify)				
Δ.	iw requires that the sbeen signed by the should be detache	ed by Ph	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		. (
of Vital Records,	The law ate has b page 2 sl	Completed			autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	Other	h (Check only one)	€ □Other /Specify)		
ion of	Attending Physic death. sector: After this by the funeral di	ation; To	27. Manyer of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation					
Division	ital or Atturs after de ral Diracto	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)		City or Town, Sta	afe)		
	To the Hospital or within 24 hours after To the Funaral Direction completely filled in E	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place, nd/or investigation, in my opinion, death occurred	red at the time, date a	and place, and due to the cause(s)		
	5 W 5 0		30. Name and address of person who completed cause of death (Item 23a	ndul D-24539	5 6	010205		
K_	(3)		Berwa Laxini N. MD. 7700 ObBrano	hAVE. Suite 101 Elint	on, MD 20	735		
	Regist	ate rar	JAN 0 4 2005	park				
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DHMH 17 Rev 1/2001

			Registrar	ate of Maryland / Do	epartment of Health and I Certificate of Death	Reg. N		42869
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last) Jane G. Muskie 4a. Facility Name (If not institution, give stree		4b. City, Town, or Location of Death		2004 Yeer 2004 Sec. County of Death	3. Time of Death 9:15 PM
	Funeral Director		4982 Sentinel Drive 5. Social Security Number 004.22.4387 6. Sex 1□ M	7. Age (In yrs. last birth	Months Days Hours Min		Montgomery 9. Birthp Coun 27 Mai	place (State or Foreign
	D	ctor	Usual Residence of Decedent 10a. State 10b. County MD Montgomery	10c. City, Town				10d. Inside City Limits 1
	th with the 23s or 28	Funeral Director	10e. Street and Number 4982 Sentinel Dr. #2	06	10f. Zip Code 20816	10g. C	Citizen of What Coun	ntry?
960	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If terms 23a or 28a-1 show amportent: If term 27 te marked other then "natural", or items 23a or 28a-1 show importent: If term 27 te marked other then "natural", or items 23a or 28a-1 show any introproper or items 25a or 28a-1 show and introduced in the Market Examiner or until edge.	by Funer	1 Never Married 2 Married 1	/as Decedent Ever in U.S. rmed Forces? ☐ Yes 2 ☒ No Yes, Give ear or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: Whit	etc.
21215-0036	d within 72 ho giene. Ir then "natu	Completed by	15. Decedent's Educatio (Specify only highest grade con Elementary/Secondary (0-12)	ollege (1-4or 5+)	lecedent's Usual Occupation Give kind of work done during most of wor ife. DO NOT use retired) Iomemaker	rking	Kind of Business/Ind	dustry
Maryland	ould be filed I Mental Hyg narked othe	To Be C	17. Father's Name (First, Middle, Last) Millage Guy Gray		Mertie	ne (First, Middle, Maide Jackson		
	es 1 and 2 st of Health and f item 27 le n Lother treun		19a. Informant's Name/Relationship (Type, F Stephen Muskie / So 20a. Method of Disposition XXBurial 2 Cremation 3 Remo	n 835	Mailing Address (Street and Number or RL Chesham Rd., Harr: Disposition (Name of crematory or other place)	isville, NH		
Baltimore,	permit. Pag Department Importent: I any injury o		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funding Service Licenses	Ceneter	on National Jan. 4 22. Name and Address of Facility Jos 5130 Wisconsin Ave		's Sons In	
	Physician /Medical		23a. Part1. Inter the disease, or complication shoth, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	ns that caused the death. Do no use on each line. Inanition Due to (or as a consequence of	t enter the mode of dying, such as cardiac			Approximate Interval Between Onset and Death Months
	Examiner	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	fultiple Infarc Due to (or as a consequence of	t Dement i a		12	years
8760,	certificate be executed inding physician and ise as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Hypertension Due to (or as a consequence of	:		3	years
O. Box 6	the death certifii y the attending p ched for use as	Physician/Med	in the past 12 months?	yes, outcome of pregnancy □ Live birth 2 □ Fetal death □ Pregnant at time of death □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
rds, P.	w requires that been signed by should be deta		Part II. Other significant conditions contributions Hyperlipemia	ting to death but not resulting in t	he underlying cause given in Part I.		use contribute to th 2 ☑ No 3 ☐ Prob	ne cause of death?
Vital Records,	aw 2 st	Completed by				24a. Was an autopsy performed? 1 ☐ Yes 2€€	prior to con death?	psy findings available mpletion of cause of 2 No
Division of Vit	ding Phy n. After this tuneral d	atlon; To Be	25. Was case referred to medical examiner? 1	ial: 1 Inpatient 2 ER/Outp ia. Date of Injury (Month, Day Year) 2 ER/Outp 28b. Tin	atient 3 DOA Other. 4 Nursing H	ome 5 Residence 28d. Describe how inj		v)
Divis	Dire	Certification;	4 Homicide	te. Place of Injury - At home, farm building, etc. (Specify)		28f. Location (Street a City or Town, Sta	ife)	
	To the Hospital within 24 hours of the Funerel completely tilled	Medical	(Check only 2 Medical Examiner:	n: To the best of my knowledge, On the basis of examination and/ and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occu	rred at the time, date a	nd place, and due to	the cause(s)
	20		& ShiC	MAN	29c. License number D39456		ember 27,	
_			30. Name and address of person who comple Lila McConnell, MD	5530 Wisconsi	n Ave. N.W. #1400,	Chevy Chas	e, MD 20	815
	Sta Registi		31. Date filed (Month, Day, Year)	2. Registrar's Signature	rade			

DHMH 17 Rev 1/2001

		For State Registrar	State o	f Marylan		artment rtificate			and Me		giene	04	428	70
	Ä	Decedent's Name (First, Middle	e, Last)							2. Date of Dea	ith		3. Time of	
Physici		Donald	J	Ma	urphy					Decembe	er 31,	2004	7:50	АМ
/Medic Examin		4a. Facility Name (If not institution			<u>arpiry</u>	4b. City, To	own, or	Location o				nty of Death		
		Frederick Mem	morial Hos	pital		Frede	eric	:k			Free	derick	ζ	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1				8. Date of Birth (Month, Day	1	9. Birth	place (State o	or Foreign
Director		213-46-9336	1 X] M 2□ F	58	Yrs.	MOTHERS	Days	Hours	Min.	Sept.21			ntry) sylvan	ia
p v		Usual Residence of Decedent 10a. State 10b. County		10c Cit	, Town or Lo	antinn								
sho	ō	Maryland Frede		Too. Oily	Jeffe								10d. Inside C	ıty Limits 2 X iNo
the N	ect	10e. Street and Number	ELICK		Jeile		and a				10- 011	(110 - 5		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. The Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event. The Maxical Examinant was the notified at once.	Funeral Director	3828 Bedford Dr	rive			10f. Zip C		1755			10g. Citizen d Unite	ed Sta	,	
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or its	Ē	1 Never Married 2 Mar	ned 1 Y Yes	2 No 190	0				, Puerto F	lican, etc.)		lack, White,		
iral;	d by	3 Widowed 4 Divorced	If Yes, Gi Year or D	ve 197	0	1⊡ Yes 2√X	El No	Specify:			Spec	oify: Wh	ite	
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Hygie Hygie thar i		17. Father's Name (First, Middle,	Last)						r'e Namo	(First, Middle,				,
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should Me mark	ဥ	Robert William 19a. Informant's Name/Relations			19h Mailir	na Address (5	Street a			ae Kies Route Numbe	-	m State 7i	n Codal	
IN ac III ac 27 Is r treu		Cindy Murphy /								ferson,			0 0006)	
s 1 ar f Hea f Hea otha		20a. Method of Disposition			lace of Dispo	sition (Name	of	-	Da	_	20c. Location		own, State	
Page ent o nt: If		1 Surial 2 Cremation 4 Donation 5 Other (S		State	ferson	•		1	11.12	005	offord	on N	larylan	d
mit. I partm		21. Signature of Funeral Service		Jer		. Name and				auffer				ıu
P F F F S		purtney	Sta	uller	16	21 Оро	ssu	mtowr		e, Fred				
		23a Part1. Enter the disease, in the last restriction or heart failure.	complications that	aushod me death									Approximat	θ
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/Medical		resulting in death)	aDue to	(or as a consequ		01100	AV P	iova	2000	al.	seas	e	10 y	CONS
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that the deathed by the atte	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unkn			3 0 11 10 10 1000								
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quires n sign		Prosta	rte a	deno	care	non	ra			1 Y	es 2 🗆 No	3 🗌 Prot	pably 4	Inknown
law requir as been si 2 should	ojet	,								24a. Was a	ın 24t). Were auto	psy findings	available
ilcian: The lav certificate has rector, page 2	Completed							-		autops	med2 2 No	prior to co death?	impletion of c	ause of
ysician: The is certificate hadirector, page	0	25. Was case referred to medica	1					26. Place	of Death	Check only on		1 🗆 Yes	28 No	
Physici Physici this ce	To B	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA	Othe	F		e 5 Reside		ther (Specia	(v)	
ding Ph After th funeral		27. Manner of eat 1 Natural 5 ☐ Pendir	28a. Date (Mon	of Injury th, Day Year)	8b. Time of Injury	280	. Injury Work	at		3d. Describe h			,,	
endir eath. or: A	catic	2 ☐ Accident investi	gation			М		es 2□N	No					
or Att	Certification;	3 Suicide 6 Could 4 Homicide determ	singal 288. Place	of Injury - At ho ng, etc. (Specify	me, farm, str	eet, factory, o	office		28	Sf. Location (Si City or Town		nber or Rura	al Route Num	ber,
urs at urel Dital of urel Dital														
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funariel Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical	29a. Certifier Certifyir (Check only one)	ng Physician: To the Examiner: On the b	asis of examinat	wledge, death ion and/or inv	n occurred at restigation, in	the time my op	e, date and inion, deat	d place, ar h occurre	nd due to the call at the time, d	ause(s) and r ate and place	nanner as s e, and due t	tated. o the cause(s)
thin (Mec	29b. Signature and title of certifie		ner stated.		29c. I	icense	number		2	9d. Date sign	ned (Month	Day Year)	
F 3 F 8		· 00.	4/1		IIN		~ ·	710	7		_			
X		30. Name any address of pe	o completed caus	se of death from	23a) (Type	Print)	5	11-6		4	/ /	-6	MD:	2
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Registr	rar		- 2003		100	Contract of	0							

			1 - For State Registrar	State of Ma	-	epartment of Certificate of			giene 00 L	+ 42871
ı	Physici	an	1. Decedent's Name (First, Middle	_				2. Date of Dea		3. Time of Death
	/Medic	cal	Mary	Helen	<u> </u>	Makle	71 - A-1V		er 26, 200	
	Examin	ıer	4a. Facility Name (If not institution, Southern Maryla	•		4b. City, Town, Clint	or Location of De	eath	4c. County of Di	
	Funeral		5. Social Security Number		e (In yrs. last birth	day) If Under 1 Year	r If Under 24 H	Irs. 8. Date of Birt		
	Director		218-30-3001	1 □ M 2 X P	71 Y	Months Davs		in. 8. Date of Birt (Month, Day December 1	2,1933 Ma	Birthplace (State or Foreign Country) ryland
	pu 🗼		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	art agation				Land Invite Charles
	faryla shov	ō	Maryland Prince	Coorgos		DI LOCATION				10d. Inside City Limits 1 Yes 2 No
	28a-f	Directo	10e. Street and Number	Georges	Clinton	10f. Zip Code			10g. Citizen of What	
	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Examinar must be inclified at	i Di	6009 Lottie Pl	.ace		20735			USA	
	death	Funerai	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. Was Decedent of If Yes, specify Cul	Hispanic Origin?	(Specify Yes or No-	14. Race - A	merican Indian,
0	or it		1 Never Married 2 Marri	ed 1 ☐ Yes 2 ☐ X	10	1 ☐ Yes XXNo		1000, 000,	Specify: B	
Ś	hours tural'	ed by	3 Widowed 4 Divorced	Year or Dates:	1 160 5	ecedent's Usual Occu				
'n	in 72 n "na dedic	plete	(Specify only highes	t grade completed)		Give kind of work done ife. DO NOT use retire	apation a during most of v ad)	working	16b. Kind of Busine	ss/industry
7	filed within Hygiene. Ither than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5		memaker			Domestic	
2	tal Hy d other	Be (17. Father's Name (First, Middle, I	*				Name (First, Middle,		
7 2	should I	²		ickeral			Mary	R.	Washingto	
	d 2 shoth and hand 7 is m		19a. Informant's Name/Relationsh James Preston	_{iip (Type, Print)} Makle/Husban		Mailing Address (Stree 9 Lottie E				
บั	iit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan triment of Heatth and Mental Hygiene, critant: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show injury or other traumatic event, the Medical Examinar must be routilised at 8a.		20a. Method of Disposition	Harrie/Hasbar		Disposition (Name of crematory or other pla		Date	20c. Location - City	
2	ages ant of it: if li y or c		1 Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sc			crematory or other pla ers Cath C		2/30/04 14		
	pernit. Pag Department Important: I any injury o		21. Signature of Funeral Service L		pt. ret	22. Name and Addr	4	2/30/04	araorr, m	aryrana
Ď	Dep Imp any		Odessa	Offer	MO1323	Adams Fun	eral Hon	ne P.A. Ac	juasco, Ma	ryland
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each lir	the death. Do no	t enter the mode of dy	ing, such as card	liac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ma	This	re C	US			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of	. 0	12		0'	
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		1	year	0			
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Ď	v requires that the death certific been signed by the attending p should be detached for use as i		IF FEMALE:	220 Maria automa	-4					
200	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	hysician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death	3 Ectopic pregnand	су		23d. Date of o Month	delivery Day Year
j.	the dr y the sched	ysi	1 ☐ Yes 2 ☐ Nen 9 ☐ Unknown	9□ Unknown	Timo or dodgir	on other (specify)				
Ž.	s that ned b e deta	by Pi	Part II. Other significant conditio	ns contributing to death bu	ut not resulting in t	he underlying cause g	iven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
cords,	w require been sig should b		1/2/200	Jones	con	,5/16	and	1 Y	es 25 No 3□	Probably 4 □Unknown
ב כ	law re as be 2 sho	Completed	andart	erack	men (2001)	24a. Was a		autopsy findings available o completion of cause of
<u> </u>		Com	Precome	niea				perfor		?
Ma	ysiclan: The law is certificate has t director, page 2 s	Be	25. Was case referred to medical examiner?	Hamital				Death (Check only or	ne)	
5	al this	To.	1 ☐ Yes No 27. Manner of eath	Hospital: patie		attent 3 DOA			lence 6 Other (S)	pecify)
	ding Ph h. After th funeral	tion	1 Natural 5 Pending 2 Accident investig	(Month, Day	Year) 200. 11	ıry Wo	ork? ☐Yes 2☐No	20d. Describe fi	low injury occurred	
UNISION	Atten er deat ector: by the	ertification:	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of Inju	ury - At home, fam	n, street, factory, office			Street and Number or	Rural Route Number,
5	s afte of Dire	Cert	4 Homicide	building, etc	с. (Spacity)			City or Tow	m, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificacompletely filled in by the funeral director.	edical	(Check only 2 Medicel E	Physician: To the best of xaminer: On the basis of	examination and/	death occurred at the tor investigation, in my	time, date and pla opinion, death or	ace, and due to the occurred at the time, o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	ithin 2 o the	Med	29b. Signature and time Streentifier	and manner sta		29c. Licen	ise number		29d. Date signed (Mo	nth, Day, Year)
	⊢≯⊢ŏ		Mar	mo		DO.	225	7	Pec 26	2004
			30. Name and address of person value (Month, Day, Year) DEC 2	who completed cause of de	eath (Item 23a) (T	/pe, Print) 4/3/	Pis	coTa	1002 /	RS
N	1P6		Kene Gra	ice My	7	clin	Ten	mo	207	35
	Sta Registr		31. Date filed (Month, Day, Year)	2004 32. Posistra	ar's Signature	Snorth &				
	ricgisti		52050	-00.						

			For State Registrar	State of M	aryland		artment o				giene	004	42872
	Dhysisi	an	1. Decedent's Name (First, Middle							2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medio		Warren	Thomas	Ma	son				12	28	04	1940 M
	Examir		4a. Facility Name (If not institution			Vi-		m, or Location			4c. C	ounty of Deal	•
			PENINSULA REGIO					5441360				Hesm.	
	Funeral Director		5. Social Security Number 215–16–2736		ge (In yrs. Ia 82	st birthday) Yrs.	If Under 1 Y Months Da	ear If Unde ays Hours	Min.	8. Date of Birth (Month, Day 7/17/19	7, Year) 22		thplace (State or Foreign ountry) Yland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation	-					10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23e or 28e-f show other treumatic event. It is Marical Examiliar retrount be notified at	5	Maryland Wicon	nico	Sa	lisbu	cv						1 ☐ Yes 2 X No
	the 1	rect	10e. Street and Number		1		10f. Zip Cod	de			10a. Citize	on of What Co	ountry?
	With 3e or	D	160 Onley Road	E			2180				USA		Surriy.
	ms 2:	Funeral Directo	11. Marital Status	12. Was Decedent		i. 13. V			Origin? (Spe	cify Yes or No- Rican, etc.)	14	I. Race - Ame	erican Indian,
(0	r Her	Fur	1 Never Married 2 Marri	Armed Forces? ed 1 ☐ Yes 2 🛣						Rican, etc.)		Black, Whit	
03(al', o	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 □ Yes 2 1 ₹	No Specif	y:		S	pecify:	white
21215-0036	72 ho	Completed	15. Decedent (Specify only highes			16a. Deced	dent's Usual Or kind of work de	ocupation	act of working	20	16b. Kind	of Business/	/Industry
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	filed with Hygiene. other ther	Co	12	2		Poli	ce Offi					Enforc	cement
Maryland	tal H d oth	Be	17. Father's Name (First, Middle, I							(First, Middle,		*	
yla	should be nd Mental marked o	ည	Elsworth F. Mas							ristine			
lar	2 sho and is mu		19a. Informant's Name/Relationsh							l Route Numbe			
	and lealth m 27 her tr		Christine L. Ca	innon/daught						sonsbur			
Ore	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from State	147 i Cei	metery, crer.	sition (Name on the natory or other Memori	place)				ation - City or	
Ë	men tent: jury		* 4 □Donation 5 🖸 Other (Sp		nt Wic	Park	Menori	aı	1/3/	2005	Sali	isbury,	, בעוניין
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21 Signature of Funeral Service I			22 H	Name and A	ddress of Fac V Funer	cal Ho	me Prof	essi	onal A	ssociation
_	0 D = € 0		Nava H. (A	111111111111111111111111111111111111111	FSP	5	01 Snow	v Hill	Rd.,S	Salisbur	y,MD	21804	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each l	d the death. ine.	Do not ent	er the mode of	dying, such a	s cardiac o	r respiratory arr	est,		Approximate Interval Between
18	Physician		Immediate Cause (Final disease or condition	a as	spira:	Lon	ONR	umon	100				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):							(orange
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9 ×	eath certifica attending ph for use as t	Physician/Med	IF FEMALE:	22a lituan autaema	of average								
Вох	attenc for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal o	death 3	Ectopic pregn				230	 d. Date of deli Month 	livery Day Year
o.	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	it time of dea	atn 5∟	Other (specify	/)					
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3ec	has t	Completed	hypertensio	^						24a. Was a autops perfori	sy	24b. Were au prior to death?	utopsy findings available completion of cause of
<u>=</u>										1 ☐ Yes		1 🗆 Yes	2 No
Vital	Physicien: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othor		(Check only or			
of	Phys this al dir	2	1 Yes 2 No 27. Manner of Death	Impatio		R/Outpatien 28b. Time of				ne 5 Reside			cify)
n	ling f	lo	1 □ Hatural 5 □ Pending		ay Year)	Injury		Injury at Work?		8d. Describe h	ow injury o	ccurred	
Sic	Attending r death. ector: After by the fune	icat	2 Accident investig	ot be 290 Blood of Ini	iun. At hom	20 form etc		1 ☐ Yes 2 [_	19f Location (C	tmat and h	Number or Dr	ural Route Number,
Division	I or Attendated after death Director:	Certification:	4 Homicide determine	ned 28e. Place of Inj building, et	tc. (Specify)	ie, iann, sin	өөі, тасіогу, оп	ICO		City or Town		vumber or Hu	Irai Houle Number,
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	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical 8	Examiner: On the basis of and manner st	of examination	on and/or inv	estigation, in r	ny opinion, de	ath occurre	ed at the time, d	ate and pi	ace, and due	to the cause(s)
	ithin o the	Me	29b. Signature and title of certifier				29c. Lic	ense number		2	9d. Date s	signęd (Month	h, Day, Year)
	⊢ 3 ⊢ ŏ		1//	1/			7	>>06	777		10	1001	104
7			30. Name and address of person of	State of the state	death /ltom /	23a) /Tune	Print)	-500			10	7 < 1/	· /
			So. Marrie and address of person to	Silvia.	To A	Zuan (Type,	~		Reg	in l	redic	1 00	to
	Sta	ite	31. Date filed (Month, Day, Year)		rar's Signatu	ire a	Sport	nsula	TC COM	IONAL VV	TEATE	Colich.	n we
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7		Physic /Med Exam
		D

			1 - State Registrar		Cert	tificate of	Death		Reg. No.	42013
	- · · ·		1. Decedent's Name (First, Middle, Last)					2. Date of De Month		3. Time of Death
	Physici /Medic		Lucy	Martine:	Z			Dec.	29°, 2004°	8:15ДМ м
	Examin		4a. Fecility Name (If not institution, give s Salisbury Nursing		nter	4b. City, Town, o	r Location of Death Salisbur	y, Md.	4c. County of De Wicomi	
	Funeral Director		5. Social Security Number 6. Sex 148-22-1980 Usual Residence of Decedent	7. Age (In yrs. la	ast birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit (Month, Date 4/4/19	*	irthplace (State or Foreign Country) erto Rico
	Maryland a-f show	tor	10a. State 10b. County Maryland Wicomic		, Town or Loc lisbury					10d. Inside City Limits 1XXYes 2 ☐ No
	h with the	ai Director	10e. Street and Number 200 Civic Ave.			10f. Zip Code 21804	4		10g. Citizen of What (Country?
980	d within 72 hours after death with the Maryland Jene. Ir than "natural", or items 23a or 28a-1 show tre Mudical Exand or must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.\$ Armed Forces? 1	If	Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto SpecifyPuert	Rican, etc.)	Black, Wh	nerican Indian, nite, etc. Spanic
21215-0036	within ane. than "	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give k life. D	ent's Usual Occup ind of work done O NOT use retired	du <i>rina most of worki</i>	ng	clothing	· ·
Maryland 2	ld be file ental Hyg ked othe ic evant,	To Be C	17. Father's Name (First, Middle, Last) Juan Alvarado				18. Mother's Name	(First, Middle Zayas	, Maiden Sumame)	
	nd 2 shi lith and 27 is m r traum		19a. Informant's Name/Relationship (Ty) Santos Martinez/Son	n	308	W. Lond	don Ave.,	Salisb	er, City or Town, State	301
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition 1 ☐ Burial 2 ☒Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Sal	emetery, crem. isbury	ition (Name of atory or other place Cremato	$_{ m ry}^{(s)}$ 1/07/2		Salisbury	, MD
Bal	permit. Departr Importe any inju		21 Sign ture of Funeral Service License		SP 50	Name and Addre 11oway F 1 Snow H	uneral Ho ill Rd.,S	me Pro: alisbu	fessional A	ssociation
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death le cause an each line. Due to for as a consequ	rere	r the mode of dying a second			Deserge	Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
.O. Box 6	he death certific the attending p ched for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 □1	Ectopic pregnancy Other (specify)	1		23d. Date of d Month	elivery Day Year
<u>α</u>	quires that the de in signed by the a uld be detached f	by	Part II. Other significant conditions con	tributing to death but not resu	ulting in the un	derlying cause giv	en in Part I.		tobacco use contribute Yes 2 No 3	to the cause of death? Probably 4 Unknown
I Records,	iician: The law requ certilicate has been rector, page 2 shoule	Completed							s an psy prior to death? 2	autopsy findings available o completion of cause of
Vital	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	lospital:		Oth	26. Place of Death			
of	Phys this ral di	tion: To	27. Manner Teath 1 Satural 5 Pending	1 ☐ Inpatient 2☐ 1 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injur Wor	4 Wursing Ho		idence 6 □Other (Sp how injury occurred	pecify)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office			(Street and Number or www., State)	Rural Route Number,
	he Hospit n 24 hours he Funera	Medical C		sicien: To the best of my knowner: On the basis of examinat and manner stated.						
	To the within comp	W	29b. Signature and title of prtifier	2		29c. Licens	e number	٥	29d. Date signed (Mod	nth, Day, Year)
	Year			NS, M.D.		Print)	200 Civic	Ave.,S	Salisbury,	Md. 21804
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 3 0 2004	32. Registrar's Signat	ture	Sparks	<i>j</i>			

	_	For State Registrar	tate of Maryla	•	artment of Hoteline			ene 1. N2 0 0 4	42874
Physicia /Medic		1. Decedent's Name (First, Middle, Last)	MENCH	+			2. Date of Death Month DEC	Day Year 25 200	3. Time of Death 5:53 PM
Examin		4a. Facility Name (If not institution, give stree			4b. City, Town, or Bak	Location of Death		4c. County of Death	
Funeral Director		217-20-3700	7. Age (In y	rs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y April 4,	(ear) 9. Birth Cou 1931 PA	place (State or Foreign ntry)
faryland ahow	ō	Usual Residence of Decedent	_	City, Town or Lo					10d. Inside City Limits
with the Na or 28a-1	Director	10e. Street and Number			10f. Zip Code 21620)		g. Citizen of What Cou	
be filed within 72 hours after death with the Maryland tal Hygiene. tal Hygiene. d other than "natural", or itams 23a or 28a-f ahow event, the Madical Examinar must be mailfied.	by Funeral	1 ☐ Never Married 2 【X Married	Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	1:	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No-	14. Race - Ameri Black, White, Specify: WH	etc.
ithin 72 hours te. ten "natural", Wedical Exa	Completed b	15. Decedent's Education (Specify only highest grade contentary/Secondary (0-12)	Year or Dates: on ompleted) College (1-4or 5+)	(Give	lent's Usual Occupa kind of work done d DO NOT use retired)	uring most of worki	ng	6b. Kind of Business/Ir	
be filed wintal Hygien of other the	Be	12 17. Father's Name (First, Middle, Last)		HOMEM		18. Mother's Name	(First, Middle, Ma	OWN HOME	
12 should I h and Meni 7 ia marke raumatic	70	FRANK D. WADDELL 19a. Informant's Name/Relationship (Type, NORMAN C. MENCH/HUS	,			nd Number or Rura		City or Town, State, Zip, MD 21620	Code)
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. In more than "natur important: if item 27 is marked other than "natur any injury or other traumatic event, the Mexical once.		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Rem ' 4 □ Donation 5 □ Other (Specify)	20toval from State	. Place of Dispos cemetery, cren	sition (Name of natory or other place	p) C	Date 20	oc. Location - City or To	
permit. Departm importa any inju		21. Signature of Funeral Service Licensee	bei	FE	LLOWS HI	CÉÉNBEIN COAD, CHE	& NEWNAN	M FUNERAL I	HOME, P.A.
Physician /		23a. Part1. Enter the disease, or o mprication shock, or heart failure. List off one commediate Cause (Final disease or condition resulting in death)	ons that caused the deause on each line. Due to (or as a cons	ar 4	er the mode of dying	g, such as cardiac o	or respiratory arres	t,	Approximate Interval Between Onset and Death
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cate be executed physician and the burial-transit	dicai Examin	resulting in death) Last	Due to (or as a cons	equence of);					
ath certifi titending I for use as	Physician/Me	in the past 12 months?	If yes, outcome of pred 1 ☐ Live birth 2 ☐ F- 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
uires that the de signed by the a	by	Part II. Other significant conditions contrib	uting to death but not	resulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
	Completed						24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of
Physician: Th rthis certificate	To Be	25. Was case referred to medical examiner? □ Yes 2 No 1 Yes 2 No	1 M Inpatient 2	ER/Outpatien		4 Nursing Hor		ce 6 Other (Specif	у)
Attending or death. actor: After by the fune	Certification:	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year, 28a. Place of Injury - A building, etc. (Spe	t home, farm, stre		? ′es 2 □ No		et and Number or Rura	I Route Number,
To the Hospital or within 24 hours afte To the Funaral Dir completely filled in	edicai Ce	29a. Certifier Certifying Physicia (Check only one)	On the basis of exam	knowledge, death	occurred at the time restigation, in my op	e, date and place, a	and due to the caused at the time, date	se(s) and manner as s a and place, and due to	lated. o the cause(s)
To the within 2 To the comple	Mec	20h Sistatura actitila at-attar	and manner stated.	residen	29c. License	number 6435E		Dec. 1	Day, Year)
		30. Name and address of person who comp		tem 23a) (Type,				+ Baltima	
Sta Registr	- 94	31. Date filed (Month, Day, Year)	32. Registrar's Si		Acosti I				

		1	For State Registrar	State of M	laryland / Depa <i>Cer</i>	rtment of Heal		al Hygiene	004	42875
F	hysicia	an	Decedent's Name (First, Middle, La GEORGE ROBERT M	,			Mo	te of Death onth Day CEMBER 21	Year 2004	3. Time of Death 9:32 P
	/Medic Examin		4a. Facility Name (If not institution, giv FREDERICK MEMORI			4b. City, Town, or Loca FREDERICK			DERICK	
	uneral rector		210-40-0000	ex 7. A	ge (In yrs. last birthday) 59 Yrs.		ours Min. 08/2	te of Birth onth. Day, Year) 21/1945	9. Birthpl Count Delav	lace (State or Foreign try) Nare
death with the Maryland	or 28a-f show be notified at	-	Usual Residence of Decedent 10a. State 10b. County Maryland Frede 10e. Street and Number	rick	10c. City, Town or Lo	derick 10f. Zip Code		10g. Citize	10 an of What Coun	0d. Inside City Limits 1 ☐ Yes 2 ☐ No try?
J36 urs efter death wit	r than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at	<u>a</u>	6021 Greenfield D 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Tyes, Give Year or Dates	9 No	21703 Was Decedent of Hispan f Yes, specify Cuban, Me	ic Origin? (Specify Ye exican, Puerto Rican, ecity:	etc.)	A 1. Race - America Black, White, e Specify: Whit	etc.
	erthan "nature t, the Modical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0·12) 12	College (1-40)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired) it Manager	g most of working	Cons	of Business/Ind	
and pe	D A	To Be	17. Father's Name (First, Middle, Last George Moffett	·)			Mother's Name (First	a Newsham	1	
Mar nd 2 sh	7 is m traum		19a. Informant's Name/Relationship Patricia Moffett			ng Address (Street and A pland Lane,				Code)
altimore,	Important: if Itam 27 i any injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Control of	☐Removal from Stat	[®] Chesapeake C	natory or other place) remation Cente	-		ation - City or To	
Balt permit.	any inj		21. Signate of Funeral Service Lice	llows	Fe 3	Name and Address of llows, Helfent 70 W.Cypress S	ein & Newman Freet, Milli	Funeral H	me. P.A. 21651	
/M Exa	dedical aminer streams and amine	dical Examiner	Sa. Part1. Enter the disease, or conshock, off-eart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to miniocials cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	as a consequence of): as a consequence of): as a consequence of):	er the mode of dying, su Exocurbo Lygin	Arm defect	ency		Approximate Interval Between Onset and Death Acys
Records, P.O. Box 68760, The law requires that the death certificate be executed	led by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 ☐ Fetal death 3 [at time of death 5 [□Ectopic pregnancy □ Other (specify)			3d. Date of delive Month	ery Day Year
rds, P.	6 8	b	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause given in	Part I. 2	3e. Did tobacco us	se contribute to th	
	certificate has been si irector, page 2 should I	Completed						4a. Was an autopsy performed? ☐ Yes 2 No	prior to cor death?	psy findings available mpletion of cause of 2 \(\square\) No
of Vita Physician:	is certificate ha	o Be (25. Was case referred to medical examiner?	Hospital: 1 Mon	atient 2 ER/Outpatie	Other	Place of Death (Che		□Other (Specif	v)
Division of	두교	$1 \vdash 1$	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of I		28c. Injury at Work?		Describe how injury		
DIVIS al or Atte	Director d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	200. Place of	Injury - At home, farm, st etc. (Specify)	reet, factory, office	28f. Le	ocation (Street and lity or Town, State)	Number or Rura	I Route Number,
Division To the Hospital or Attending	within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	29a. Certifier 12 Certifying F (Check only one) 2 Medicel Exe	Physicien: To the be eminer: On the basis and manner	est of my knowledge, dea s of examination and/or in stated.	th occurred at the time, o	date and place, and do n, death occurred at	the time, date and	place, and due to	o the cause(s)
Tot	To ti	Me	29b. Signature and title of certifier			29c. License nu	mber 516	29d. Date	signed (Month,	2 2004
			30 Name and address of person wh	Son ND	of death (Item 23a) (Type	Print) TANEY	NE F	NED,	MP 2	1702
	St Regist	ate trar	31. Date filed (Month, Day, Year) DEC 2 7	2004 32. Red	istrar's Signature	fronts				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dey Year DECEMBER 20, 2004 LEROY MABREY 14:25 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 10XM 2□ F 214-28-1863 9() Yrs. AUG25, 1914 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No KENT MILLINGTON 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 31906 RIVER PARK ROAD 21651 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: WHITE Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EQUIPMENT OPERATOR 5 TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES A. MABREY SUSIE SQUSE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD SQUIRES/POA 13098 HICKORY DRIVE, GALENA, MD 21635 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State CRUMPTON CEMETERY 12/23/2004 4 ☐ Donation 5 ☐ Other (Specify) CRUMPTON, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 370 W. CYPRESS STREET, MILLINGTON, MD 21651 23a. Part 1. Enter the disease, or complicatops that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death FALL Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): THERMIA 0 Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Physician Medical Examiner

attending physician and for use as the burial-transit

sate has been signed by the a page 2 should be deteched a

certificate

the

al or Attanding Physicien: TI s efter death. I Director: After this certificate

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 Funaral D

To the Within 2 To the I

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

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Completed

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Certification:

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Physician

/Medical

Examiner

Directo

Funeral

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10a. State

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylend nent of Health and Mentel Hygiene. ant; if Item 27 is marked other than "natural", or Items 23e or 28e-f ahow ary or other treumatic event, the Medical Evanment must be notified at

altimore, Maryland 21215-0020

r than "natural", or Items 23e or 28e-f ahow the Medical Examiner must be notified at

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

2000 Cartifica

4 - Homicide

(Check only one)

24a. Was an autopsy performed? 1 Vos 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury et Work?

28d. Describe how injury occurred

INABILITY 28f. Location (Street and Number or Rural Route Number of City or Town, State)

Carlying Physician: To the basis of the work of the cause

29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of

5 Pending

investigation

6 ☐ Could not be determined

D36054

1 Tyes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bldg B Chestertown Mo 21020 J. Shanahan HD 1205 Hetrick 3°2004 Registrar's Signature

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

11:41

Pace of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

20 0

State Registrar

DHMH 16 Rev 6/95

		For	State of Maryland	d / Depa	ırtment of	Health ar		•	eue Legibi	4 42877
		1 - State Registrar		Cer	tificate o	f Death			3. No.	
Physic	ian	Decedent's Name (First, Middle, Last)						2. Date of Death Month		3. Time of Death
/Medi Examir		Leone Clare 4a. Facility Name (If not institution, give s	Mitchell street and number)		4b. City. Town	or Location of		ecember	26, 200	
Exami	lei	Casey House	,		•	kville				gomery
Funeral		5. Social Security Number 6. Sex	. ,	.,	If Under 1 Year Months Day	ar If Under 24	4 Hrs. 8 Min.	Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
Director		395-03-2225	M 20 F 89	Yrs.	was a say	110010		an. 12,		Wisconsin
land www.		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
Mary e-f sh	to	Maryland Montgomer		C41.	or Cari	na				1 ☐ Yes 2X No
th the	Directo	10e. Street and Number	у	- 211	er Spri			10	g. Citizen of Wha	at Country?
23a d	ral	10000 Brunswick Av	renue #420			910			United S	States
er des	Funeral		12. Was Decedent Ever in U.S Armed Forces?	5. 13. V	Vas Decedent of Yes, specify Ci	f Hispanic Origin Juban, Mexican, I	n? (Specii Puerto Ric	fy Yes or No- can, etc.)		American Indian, White, etc.
rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	☐Yes 2∏XN	lo Specify:			Specify:	TT 1.
If Z. 12.1.2.000.000.000.000.000.000.000.000.0	ted	15. Decedent's Educ	cation	16a. Deced	ent's Usual Occ	cupation	-50	10	6b. Kind of Busir	White ness/Industry
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an y allo K 1 K. 2 should be filed withir and Mental Hygiene. Is marked other than sumatic event, the M.	2	Mathias J. Be 19a. Informant's Name/Relationship (Typ.	ernklau	10b Mailin	a Addrasa /Ctra	C1a		Wint	ers City or Town, Sta	To Oak I
ite, INITED FIGURES AT A 12 TO 1000		Karyn S. Mitchell/				eld Roa				land 20853
t Hear		20a. Method of Disposition	20b. Pl		sition (Name of natory or other p		Dat	-		ty or Town, State
Pages nent of I		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	ellioval irolli State			natory 1	2/20	/2004	Odentor	n, Maryland
Dealth 101 C, 1910 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.	1	21. Signature of Funeral Service License				dress of Facility ne Crema				
a 88 5 8		Juanita R4	Romas		-					D. Box 784 ville, MD21029
		23a. Part 1 Enter the disease, or complice shoot, or heart failure. List only on	cations that caused the death e cause on each line.	. Do not ente	er the mode of d	ying, such as ca	ardiac or r	espiratory arres	it,	Approximate Interval Between
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/Medical Examiner		resulting in death)	Due to (or as a consequ				-			
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uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Pneumonia							
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artifica ing ph e as tl	ed	IF FEMALE:								
eath certific attending pl	Physician/M	23b. Was decedent pregnant 23	3c. If yes, outcome of pregnar 1☐Live birth 2☐Fetal	déath 3	Ectopic pregnar	псу			23d. Date o	,
the de	ysic	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of de 9□ Unknown	ath 5	Other (specify)				i i i i i i i i i i i i i i i i i i i	Day , Gai
ires that the de signed by the a		Part II. Other significant conditions con	tributing to death but not resu	Iting in the un	derlying cause	given in Part I.		23e. Did toba	cco use contribu	ite to the cause of death?
quires n sign	d by							1 ☐ Yes	2 X]No 3[Probably 4 Unknown
aw requir	ompleted							24a. Was an	24b. Wei	re autopsy findings available
sicien: The law scertificate has t lirector, page 2 s	E O							autopsy performe 1 Yes 2	ed? dea	
sien: artifica ctor. p	Be C	25. Was case referred to medical examiner?				26. Place o	f Death (0	Check only one)	21	Yes 2X No
ding Physicien: The h. After this certificate h. funeral director, page	은	1 ☐ Yes 2 No		R/Outpatient	3□ DOA	Other: 4 Nurs	ing Home	5 Residen	ce 6 💢 Other ((Specify) Hospice
ding Phys	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In W	jury at fork?	280	d. Describe how	injury occurred	
Violity Attence er death rector: by the	ertification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury · At hor	me farm stre		Yes 2 No		Location (Stre	et and Number	or Rural Route Number,
Dire after	erti	4 Homicide determined	building, etc. (Specify,)	, ot, 140(01), 01110		-01	City or Town,		" ridia riodia ribilibar,
bours hours unere	Salc	29a. Certifier 1X Certifying Phys	sician: To the best of my know	vledge, death	occurred at the	time, date and p	place, and	d due to the cau	se(s) and manne	er as stated.
Livision of Vital meconics, F.C. box 00100, within 24 housing the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	one) 2 Medical Examin	ner: On the basis of examinati and manner stated.	on and/or inv	estigation, in my	y opinion, death	occurred	at the time, date	e and place, and	due to the cause(s)
To	Σ	29b. Signature and little of certifier			29c. Lice	nse number		290	f. Date signed (A	Month, Day, Year)
						35635		D	ecember	28, 2004
02		30. Name and address of person who con				1110 Ma	, 2017	nd 2005	5	
Sta	ate	31. Date filed (Month, Day, Year)	Ol Muncaster M 32. Project art's Signati	nte TTTT	KOCKV1	llle, Ma	тута	11u 2003	<i>J</i>	
Regist		DEC 2 9 20	32. Pagistrar's Signati	B 15	rest o					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 2004 **Physician** Month December 2:40 A M **MEADOWS** VERONICA LIELA /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth
9-10-1919 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🖫 F Maine 85 Director 218-38-1456 Yrs. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28e-f show 10d. Inside City Limits the Medical Examiner must be notified at MD Frederick Frederick Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip C*o*de 21702 10g. Citizen of What Country? 2100-B Whittier Drive U.S.A. "natural', or Itams 23a filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic avent, the Madic once. Elementary/Secondary (0-12) College (1-4or 5+) Corp. Sec. Moving/Storage Co. Moving/Storage Co. 12years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Albert Cumming Annie Jameson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jaime Dixon P.O.Box 435 Braddock Hgts. Md. 21714 Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Smithsburg Crematory 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 12-30-2004 Smithsburg, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Eyner Servi ROBERT E. DATLEY & SON FUNERAL HOMES, P.A. 1201 N. Market Street, Frederick, Md. 23a. Part. Enter the disease, or complica shock, or near failure. List only one Approximate Interval Between Onset and Death d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Sepsis Sym Due to (or as a consequence of): **Physician** Hours /Medical Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical 88 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No certificate Division of Vital 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this After thi 27, Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funarel C completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-30 MO VND 51610 -0 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Figistrar's Signature Ave Frederick michael Tolino MO 1475 Taney 31. Date filed (Month, Man Year) 3 2005 State Registrar

			1 - For State Registrar	State of Maryla		artment of H			iene	1,2879
			Hegistrar Decedent's Name (First, Middle, Last)			timodio or .		2. Date of Deat	th	3. Time of Death
4	Physicia		William E. Miller	r				Decembe	Day Year er 27 2004	1.29 P M
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Deal		4c. County of Deat	h
			Anne Arundel Medic	cal Center			napolis			Arundel
	Funeral		5. Social Security Number 6. Sex	** **	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day,	Year) Co	hplace (State or Foreign untry)
	Director	. }	214-05-0522 Usual Residence of Decedent	92	115.			June 30	, 1912 Ka	nsas
	land ow		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Mary I sh	ģ	Maryland Anne Arur	ndel		P	Annapolis	5		1 XYes 2 No
	n 28a	irec	10e. Street and Number			10f. Zip Code		1	log. Citizen of What Co	
	4 within 72 hours after death with the Maryland jiele. I then natural; or Items 23a or 28a-f show the Medical Examinat must be notified at	Funeral Director	825 Janice Drive				21403		U.S.A	
	r dea	ne	11. Walital Status	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (9 an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ★ Vidowed 4 ☐ Divorced	1 □ Ye <i>s</i> 2 /□ N o If Yes, Give Year or Dates:		1 ☐ Yes 2☐(No	Specify:		Specify:	White
21215-0036	turat		15. Decedent's Educ	ation		dent's Usual Occup			16b. Kind of Business/	Industry
15		piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of wo d)	orking		
212	e filed within al Hygiene. I other then " vent, It a Me	Completed	12			Mechanic			United 2	Airlines
p	al Hygid d other event, I	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,		
yla	2 should be and Mental is marked o	2	Charles E. Miller					e Jane Sh		7.0.11
Maryland	s 1 and 2 should be filed I Health and Mental Hyg item 27 is marked othe other treumatic event,		19a. Informant's Name/Relationship (Typ. Karen Hepburn/dauc					napolis, i	r, City or Town, State, 2 Maryland	21403
	is 1 and 2 of Health a item 27 is other trei		20a. Method of Disposition		Place of Dispo	osition (Name of			20c. Location - City or	
Baltimore,	permit. Pages Department of I Importent: If ite any injury or o		1 XBurial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		matory or other place en Cemete		3/2005	Glen Burnie	e, Maryland
Ē	artme briteni injury		21. Signature Funeral Sarvice License	1/2					ylor Funera	
Ba	Depar Impo any ir		total E	dill					Annapolis	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the de	ath. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between
	Pnysician	2 0	Immediate Cause (Final disease or condition	Colonia	en A	ateu	1)150	cade		Onset and Death
	/Medical		resulting in death)	Due to (or as a conse	ence of):					
	Examiner	L.	Sequentially list conditions, b	. —						
	pe jis	ine	Sequentially list conditions, if any, leading to immediate case. Exercisely sequences (Disease or injury	Due to (or as a conse	equence of):					
	and and II-tran	Examine	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
8760	The law requires that the death certificate be executed to has been signed by the attending physician and te has been signed by the attending physician and age 2 should be detached for use as the buriat-transit									
687	ificate g phys as the	Physician/Medical								
ŏ	certifica anding ph use as th	N	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe		□Ectopic pregnancy	u.		23d. Date of del	,
Ξ.	death le atter	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Other (specify)			Month	Day Year
P.0	that the de led by the detached	Phy	9 🗆 Unknown		taiitai		on in Best I	22e Did to	bacco use contribute to	the cause of death?
	res tha igned l be det	by	Part II. Other significant conditions con	tributing to death but not r	esuiting in the t	inderlying cause giv	ren in Fait I.		es 2□No 3□Pr	
orc	v requir been si should	eted								
Records,	e law has b	Completed						24a. Was a autop: perfor	sy prior to	utopsy findings available completion of cause of
a T	- G							1 Tes	2 No 1 ☐ Yes	2 No
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Ott	200	eath (Check only or	ence 6 🖺 Other (Spe	city)
of		H	27. Many r of Death	28a. Date of Injury (Month, Day Year)			ry at		ow injury occurred	city)
ion	를 는 통 j	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 19ar)	Injury		Yes 2 □No			
Division	or Attendatter deatt Director: in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, si	reet, factory, office		28f. Location (S City or Tow	treet and Number or Ri n, State)	ural Route Number,
Ö	itel or A rs after ref Directled in by	Cer		4						
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edicai	29a. Certifier 1 Certifying Physical Check only 2 Medicel Examination	sician: To the best of my k	nowledge, dea nation and/or i	th occurred at the til nvestigation, in my o	me, date and plac opinion, death occ	e, and due to the courred at the time, o	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	the the the the the the	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	2	29d. Date signed (Mont	h, Day, Year)
	Viti Con		1 /11.0 /	Who All		100	2463x	3	12/27/00	1
			30. Name and address of person writing	impleted cause of death (II	tem 23a) (Type	, Print)	0	11	101	' M
			MARCO A. M	lein mo	200	2 popla	al lo	Keey S	vite 310	Huryd4
		ate	31. Date filed (Month, Day, Year) DFC 2 9 20	32. registrar's Sig	mature	Coast o		9		V
	Regist	ावा	DLU 63 60	U T WELL SHEET OUT	10 1					

			1 - For State Registrar/MEND#7p=rFH1/ 1. Decedent's Name (First, Middle, Las	3/05,BMW,Mc	laryland / Dep	artment of I rtificate of			Reg. No.	4 42880
	Physic			Nguy e n				2. Date of De Month	Day Y	3. Time of Death
	/Medi Examir		4a. Facifity Name (If not institution, give	0 3)	4b. City, Town,	or Location of De	Decembe	er 26, 200 4c. County of	
			Holy Cross Hospit	al		Silver	Spring		Montgo	omery
	Funeral		5. Social Security Number 6. Se	9x 7. A □ M 2⊠ F	ge (In yrs. last birthday)	If Under 1 Year Months Days				Birthpface (State or Foreign Country)
	Director		214-33-2193 Usual Residence of Decedent		94 Yrs.			Dec. 31	1910 7	Viet Nam
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	B Mar	ctor	Maryland Montgome:	ry	Silver	Spring				1 ☐ Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	s 23a	rai	1306 Caddington A			20901			Viet Nam	
10	tter de	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceden Armed Forces 1 ☐ Yes 2 🔀	TEVERIN U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? Jan, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. Race - Black, 1	American fndian, White, etc.
036	urs af	É	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify:	Asian
21215-0036	within 72 hours after death with the Maryland ane than "natural", or items 23a or 28a-1 show a Madical Examinat har collined at	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occup	pation	endkina	16b. Kind of Busin	
121	vithin ne. han *	ig m	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retire	id)	iorking		
	filled v Hygie other t		17. Father's Name (First, Middle, Last)		Homen	naker	18 Mother's N	ama (First Middle	Domestic Maiden Surname)	:
au	d be ental ked o	To Be	Dan V. Nguyen				UNKNOW		, ivialderi Surname)	
Maryland	should and Men marke	-	19a. Informant's Name/Relationship (T	ype, Print)	19b. Maili	ng Address (Street	1		er, City or Town, Sta	ite, Zip Code)
	and 2 salth a n 27 ls		Nhat G. Tran / Son	1						ryland 20901
Baltimore,	of He		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ I	Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other pla	ce)	Date	20c. Location - Cit	y or Town, State
ij	Pages tment of I tant: If its jury or g		`4 □Donation 5 □Other (Specify,		Gate of F					ring, Marylan
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any higher or gher traumatic event, it a Medical Exarcities must be rediffied as once.		21. Signator of Funday Service Licens 23a. Partl. Enter the disease, or comp	10 tron	, CF 3 11	.800 New	Hampsh i ı	e Ave. S	ilver Spr	RAL HOME, INC ing, MD 20904
8760,	Physician /Medical Examiner publicate properties and publication of the particular studies of th	dical Examiner	shock, or heart failure. List only of firmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	a. Coronar Due to (or as Due to (or as	y Artery Di s a consequence of): ular Fibril s a consequence of): s a consequence of):					Interval Between Onset and Death
.O. Box 6	The faw requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	Ectopic pregnancy	у		23d. Date of Month	delivery Day Year
rds, P	equires tha sen signed I ould be det	by	Part II. Other significant conditions co	ntributing to death t	out not resulting in the u	nderlying cause giv	ren in Part I.		_	te to the cause of death? Probably 4 \(\)Unknown
Il Records,		Completed						24a. Was autop perfor		e autopsy findings available to completion of cause of h? Yes 2 \sum No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		045		eath (Check only o	ne)	
of		. To	1 Yes 2 No	1 🔲 Inpati			4 🗀 Nursing		dence 6 Other (5	Specify)
lon	Attending In death.	tior	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year) Injury	Wor	k? Yes 2 □ No	200. 170301100 11	low infairy occurred	
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At home, farm, str c. (Specify)			28f. Location (S City or Tow	Street and Number of m, State)	r Rural Route Number,
	To the Hospital or within 24 hours afturing the Funeral Discompletely filled in	edicai	29a. Certifier (Check only one) 1 ☑ Certifying Phy 2 ☐ Medical Exami	sicien: To the best ner: On the basis of and manner st	of my knowfedge, death of examination and/or invated.	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occ	ce, and due to the courred at the time, of	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certaier	()/	1	29c. Licens		2	29d. Date signed (M	onth, Day, Year)
,	3		, M	Whi		H513			13.24.2	4004
			30. Name and address of person who co					Dadgar, 1	M.D.	
	Sta	te	9715 Medical Cente 31. Date filed (Month, Day, Year)	32. Pegisti	rar's Signature	TITE, MAI	гутапо 2	0000		
	Registr		JAN 032	005	rar's Signatury					

			For State Registrar		State	of Marylar	_	artment of H				giene Reg. NG	0 () 4	428	81
1	Physici		1. Decedent's Name (First, I	liddle, La	st)						2. Date of De Month	ath Day		Year	3. Time of I	
	/Medic	al -	HELEN DORIS					I			DECEMB				2:45	P ^M
	Examin	er	4a. Facility Name (If not inst					4b. City, Town, or	Location	of Death			ŕ	of Death		
	F		UNION HOSPIT 5. Social Security Number	AL 01		7. Age (In yrs.	last birthday)	ELKTON If Under 1 Year	If Under	24 Hrs.	8. Date of Bir	th	ECI		olace (State or	Foreign
н	Funeral Director		212-07-1284		_M 2 X F	87		Months La Days	Hours	Min.	(Month, Da	y, Year)	17	Cour	TLAND	, or origin
	P.		Usual Residence of Decede									,				
	show	_	10a. State 10b. Co	unty	2.1	10c. Cr	ty, Town or Lo	ocation						1	0d. Inside City 1 Yes	
	he M	Director	MD CEC	IL_		CH	ARLEST	OWN 10f, Zip Code				10- 0%-	(1			
	with											•	en or v	What Cour	ntry?	
	ns 23	Funerai	4 WATER STRE	LT		cedent Ever in U	J.S. 13.	21914 Was Decedent of Hi	ispanic Or	igin? (Spe	cify Yes or No	USA - 1	4. Rac	e - Americ	an Indian,	
36	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show idical Examinet must be mutified at	by Fun	1 □ Never Married 2 □ 3 ▼ Widowed 4 □ Dive		Armed F 1 ☐ Yes If Yes, G Year or I	2 X No live	1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 X No			Rican, etc.)			ck, White,		
21215-0036	72 hou natura		15. Dec	edent's E	ducation			dent's Usual Occupa				16b. Kin	d of B	usiness/In	dustry	
215	s within 72 piene. r than "n	pie	(Specify only I	-	de completed) (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during mos }	st of workir	ng				,	
21	ad wit	Completed	12			(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	HOME	MAKER				OWI	N H	OME		
pu	be filed ital Hygi id othar avant, I	Be	17. Father's Name (First, Mi	ddle, Last))				18. Moth	er's Name	(First, Middle	, Maiden S	Suman	ne)		
Maryland	should be nd Mental markad c	ပ္	HOWARD BLOOM							QUII						
<u>a</u>	12 sho		19a. Informant's Name/Rela				1	ng Address (Street a							Code)	
	s 1 and 2 should f Health and Mer itam 27 Is marks other traumatic	1	PHILLIP PRICE 20a. Method of Disposition	E/SOI	<u>N</u>	20b. I		AVELY FAI position (Name of	RM RO		SASTON,			601 City or To	own State	
Baltimore,	m O		1 🔀 Burial 2 □ Crema			n State	cemetery, cre	matory or other plac	1					•		
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Ba	Depa Impo any in		Y Well	4.	1/2	L		ELLOWS, HI 06 SHAMROO	ELFEN CK RO	BEIN AD, (HESTER	, MD	JNE 2	RAL H 1619	OME, P	.A.
			23a. Part1. Enter the disea shock, or heart failure	e, or com List only	plications that one cause or	each line.	th. Do not en	ter the mode of dyin-	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Betw Onset and D	/een
	Physician		Immediate Cause (Final disease or condition	000	_ a		LUNG	COLL	329A						2 DA	
	/Medical Examiner		resulting in death)	- (Due to	o (or as a consec										
		er	Sequentially list conditions, if any, leading to immediate		b. Due to	(or as a consec	MEVIM	AINO							2 DAYS	
	nsit	пiп	cause. Enter Underlying Cause (Disease or injury	~		(0. 20 2 0000	ASPIR	ATINA							1 tacma	
	execunand and all-tra	Examin	that initiated events resulting in death) Last		c. Due to	o (or as a consec		14 (1014							UNFINE	414
8760,	le be executed ysician and e burial-transit	dicai		l	d		Dusin	ACIA								
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Вох	eath certific attending p	an/h	IF FEMALE: 23b. Was decedent pregna			utcome of pregn birth 2 Teta		☐Ectopic pregnancy	,			2		te of delive	,	
O. E	at the dea by the at stached fo	Physician/Med	in the past 12 months' 1 ☐ Yes 2 1 No 9 ☐ Unknown		4□Preg 9□ Unk	nant at time of one		Other (specify)					MC	onth	Day Y	ear
<u>o</u> .	that the	Phy	Part II. Other significant co	nditions	contributing to	doath but not ro	sulting in the s	andorthring course give	on in Part	1	23a Did	tobacco us	o cont	tributa ta tl	ne cause of de	anth?
rds,	The law requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	ed by	Tatti. Other significant co		MENTIA		suiting in the t	andenying cause give	eni ni rait			Yes 2			ably 4 ⊟U	
Vital Record	aw re	Completed		PAR	MOZNIX	3210 21	BASE				24a. Was		24b.	Were auto	psy findings a	vailable
Ä	i: The lavicate has	E		CNI	LONIC	GBS7EVC	TIVS	Ucmonary	2) ומ	AK S		ormed? 2 No		death?	mpletion of ca 2∏ No	use or
ita	ysician: is certifica director, j	Be C	25. Was case referred to m examiner?			0133155		OCH ON AT 3			(Check only					
of V		2	1 ☐ Yes 2 No			Inpatient 2	ER/Outpatie	nt 3□ DOA Othe	er: 4□N	ursing Hor	ne 5⊡Resi	idence 6	□Oth	ner (Specif	y)	
		on:		ending		e of Injury onth, Day Year)	28b. Time of Injury	Worl			28d. Describe	how injury	occur	red		
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Division	= a := c	Certification;	4 Homicide	etermined	buil-	ding, etc. (Speci	ify)	reet, factory, office		-	City or To		IVUITIL,	oer or Hura	al Route Numb	er,
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•			30. Name and address of p					Print)		15	LTGN,		21180			
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			For State Registrar	State of Man		partment of Fertificate of		•	giene leg. No 2004	42882
I	Physici	_	1. Decedent's Name (First, Middle, La Warren F. F	arker				2. Date of Dea Month Decembe	Day Year	3. Time of Death 04 5:10A M
j.	/Medio Examin	er	4a. Facility Name (If not institution, given Anne Arundel Me	re street and number)	ter	4b. City, Town, o	or Location of Dea		4c. County of Dea	ath
	Funeral Director		214-84-7330	Sex 7. Age (I. 1. X M 2 ☐ F	n yrs. last birthday 42 Yrs.	Months Days	If Under 24 Hr Hours Mir		9. Bi 5 1962 Ma	inthplace (State or Foreign Country) aryland
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "helurel", or liems 23a or 28a-f show event, the Medical Examinar must be notified at	Directo	10e. Street and Number 94 College Cre	Arundel A		10f. Zip Code 21401			10g. Citizen of What C	
980	ours after de rel', or Items Examinar n	by Funeral	11. Marital Status XXNever Mamed 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Tes 2 No If Yes, Give Year or Dates:	er in U.S. 13	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Specify Yes or No- into Rican, etc.)	14. Race - Am Black, Wh Specify: B	ite, etc.
aryland 21215-0036	d within 72 ho giene. In than "netu	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 11th		(Giv life.	edent's Usual Occup to kind of work done DO NOT use retire Od Servi	during most of w d)	orking	16b. Kind of Busines. United S Naval Ac	tates
yland		To Be C	17. Father's Name (First, Middle, Last Roger Parker	· 			Deloge	ame (First, Middle, es Hunt		
≥	Health and 2 s Health an tem 27 is other treu		19a. Informant's Name/Relationship Delores Parker 20a. Method of Disposition	(Mother)	524	Annapol	itan La		r, City or Town, State, 100115, M 20c. Location - City o	d. 21401
altimore,	it. Page rtment o rtent: If njury or		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Special Service Lices) 21. Signature of Funeral Service Lices	fy)	Church	en and Addre	12		St. Marga	
ä	perm Depa Impo any l		23a. Part 1. Enter the disease, or con shock, or heart failure. List only	Pese MC6 48 nplications that caused the one cause on each line.	3	821 West	_StAı	napolis	, Md. 21	Approximate Interval Between
· -	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	a. Due to (or as a c	sells onsequence of): which	electr Zun tn	rcerl v	otivul dia	4	30 min
8760,	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c	onsequence of): Uputu onsequence of):	asive	card	ionyop	athy	25 year
O. Box 6	The law requires that the death certific ite has been signed by the atlending p age 2 should be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	☐Ectopic pregnanc☐ Other (specify) _	у		23d. Date of de Month	elivery Day Year
rds, P	w requires that been signed b should be dete	by	Part II. Other significant conditions	contributing to death but n	not resulting in the	underlying cause given	ven in Part I.	23e. Did to	bacco use contribute es 2 No 3 F	to the cause of death? Probably 4 □Unknown
I Record		Completed	Henoti	derysi	s.in c	irrhusi	5	24a. Was a autop perfor	med? death?	autopsy findings available completion of cause of s
of Vita	Physicien: The I or this certificate ha eral director, page	n; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Oate of Injury	2 ER/Outpati	of 28c Inius	ner: 4 Nursing		ne) ence 6 □Other (Sp. ow injury occurred	ecify)
Division of Vital	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director,	Certification;	1 Natural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not t 4 Homicide	De Place of Injuny	- At home, farm, s	M 1	rk? Yes 2∐No	28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	To the Hospitel or A within 24 hours after to the Funerel Direct completely filled in by	Medical	(Check only 2 Medicel Exe	hysicien: To the best of r miner: On the basis of ex and manner stated	camination and/or	investigation, in my	opinion, death occ	curred at the time, o	late and place, and du	e to the cause(s)
	Mit To Cor		29b. Signature and title of certifier Superior Management (1977)	Bernaue	o ND	29c. Licens	1083	14	PSI PSI PSI PSI PSI PSI PSI PSI PSI PSI	12004
	Sta	ite	30. Name and address of person who	completed cause of deat AWAYA 32 registrar's		Defense 1	Lighum	1 Anus	spolisin	1021401
	Registr		DEC 3 0 2	004	. 136	boards .				

Anne Mundel #37

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42883 Certificate of Death Reg. No. 3. Time of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** DEC 26,2004 12:28PM CLARENCE EDWARD PRESBURY /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Name (If not institution, give street end number) Examiner Holy Cross Nursing and Rehabilitation Burtonsville MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) B. Date of Birth (Month, Day, Year)
May . 18,1931

B. Date of Birth (Country)
May . 18,1931

B. Birthplece (State of Country)
Maryland 5. Social Security Number **Funeral** Days 1⊠M 2□ F 73 Director 220-26-4273 Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Health end Mental hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, the Medical Experimentment be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1X Yes 2 □ No Laurel Prince George's Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20723 9560 Cissell Ave Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: ģ Black 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Mechanic Private 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dora Bond Winfield Presbury 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 115010 Pinetop Ln Burtonsville, MD20866 Mary Carter- daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/31/04 Beacontown, MD Zion Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Snowden Funeral Home, P.A. 21. Signatur of Funeral Service Licenses 246 N. Washington St Rockville, MD 20850 sec 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical METATASTIC BRAIN TUMOR Examiner Due to (or es e consequence of): Examiner ettending physicien end for use es the buriel-transit Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence of) Box 68760, Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed by the e irector, page 2 should be deteched t Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown DIABETES MELLITUS TYPE II 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy Completed t□ Yes 2KfN 1 Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funerel director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) Certification: Injury 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 4 Homicide 6 To the Hospital 1\(\begin{align*} \text{Certifying Physician:} \text{ To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted. 2 \(\begin{align*} \text{Medical Examiner:} \text{ On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. edical 29a. Certifier 29d. Date signed (Month, Dey, Yeer) 29c. License number 29b. Signature end title of certifier December 26,2004 D52261 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 3415 Greencastle Blvd Silver Spring, MD 20910 Alan Segal, MD31. Date filed (Month, Dey, Year) 32. Pagistrer's Signature State JAN 03 2005 Registrar

DHMH 16 Rev 6/95

State

JAN 0 4 2005 Registrar

Kathleen M

31. Dete filed (Month, Day, Year)

gistrer's Signature 32

Smith

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

YORK-

9501 old Annapodis

January 3, 2005

			State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department State of Maryland / Department Certification Certifica	ent of H tas ate of I	lealth and M Death	lental Hy	giene Rag. No.	004	42885
1	0		Decedent's Name (First, Middle, Last)			2. Date of De.	ath		3. Time of Death
	Physici /Medic		Archie J. Pines			Decembe	r 23	3, 2004	7:10 PM
	Examin				Location of Death			County of Death	
			Babarban neeprear	ethesda nder 1 Year	a If Under 24 Hrs.	9 Date of Die		ontgomery	
	Funeral Director		5. Social Security Number 224-52-1017 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) Yrs. 1 ☑ M 2 ☐ F		Hours Min.	Month, Da	y Year)	23-1949 Cour 47 Viro	lace (State or Foreign stry)
			Usual Residence of Decedent			June 23	7 2 3	++ VII	şinia .
	rylan show	_	10a. State 10b. County 10c. City, Town or Location					1	Od. Inside City Limits
	ith the Marylan or 28a-f show e notified at	cto	Maryland Montgomery Kensington						1 ☐ Yes 2 No
	with the	Dire		. Zip Code			10g. Citi	izen of What Cour	itry?
	eath w	erai		0895 ecedent of Hi	ispanic Origin? (Spe	ecity Yes or No		ted Stat 14. Race - Americ	
	(6 after death with the Maryla or Items 23a or 28a-f shov ciltrer natat be inclifted at	Fun	Armed Forces? If Yes, s 1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No 1 Q 6 7 □	specify Cuba	ın, Mexican, Puerto	Rican, etc.)		Black, White,	etc.
Ì	rali, o	by	3 ☐ Widowed 4 ☑ Divorced Year or Dates: 1969	s 21 No	Specify:			Specify: Bla	.ck
ı	5-C	etec	15. Decedent's Education 16a. Decedent's U (Specify only highest grade completed) (Give kind of	Jsual Occupa	ation during most of worki	ing	16b. Ki	ind of Business/Ind	dustry
3	21215-0036 d within 72 hours att glene: er than "natural; or the Medical Exami	Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4or 5+) 12 Admini				Но	spital	
	d 2 filed Hygie other	ပိ	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle,			
	aryland 21215-0036 should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or Items 23e or 28e-1 show imatic event, the Modical Exercities in the incititied at	To Be	Matthew Pines		Bessie B	rown			
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	. 5 8 5				Blvd. Fo		ingt	on, MD 2	.0744
13	Ore of He if iten		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (cemqtery, crematory) Northern Vit	(Name of or other plac	Decem	ober 29	20c. Lo	ocation - City or To	own, State
0	E Page International Control		`4 □ Donation 5 □ Other (Specify) Funeral Serv			004	Cha	antilly,	Virginia
01:10	Baltimore, permit. Pages 1 a Department of Hea Important: If item any injury or othe		21. Signature of Funeral Service Licens MO0956 22. Name NO1 145	e and Addres rthern 522L L	ss of Facility Virginia ee Road	Funera Chantil	al So	ervices VA 2015	1
6			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the methods, or heart failure. List only one cause on each line.	mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	15					Onset and Death
*	/Medical Examiner		Due to (or as a consequence of):						
-230	a	<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	UMI	ONIA				
3	nsit	nine	cause. Enter Underlyin. Cause (Disease or injury						,
8	760, be executed sician and burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):						
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u.	f 68 rtifica ng ph		IF FEMALE:				-		
4	ords, P.O. Box 6 requires that the death certific een signed by the attending f hould be detached for use as	ician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopi	ic pregnancy	,		1:	23d. Date of delive Month	ery Dav Year
5	O. En de de de the de	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	r (specify)				Month	ouy rou.
4	P.O. that the ded by the detached	Physi	Part II. Other significant conditions contributing to death but not resulting in the underlying	na cause aiv	en in Part I.	23e. Did t	obacco u	use contribute to the	ne cause of death?
S	cords, P	d by		3		1 🗆	Yes 2	Prob	ably 4 Unknown
5	Cord w require been si	ompieted				24a. Was	an	24b. Were auto	psy findings available
=	(b) @ @ (c)	dmo				auto	psy prmed? _	prior to co death?	mpletion of cause of
1-7		C	25. Was case referred to medical		26. Place of Deat	1 ☐ Yes		I I I Tes	22 140
		To B	examiner? 1 Yes 2 No	DOA Oth	er: 4 🗆 Nursing Ho	me 5 Resi	dence	6 □Other (Specif	y)
	On O ding Ph h. After th funeral	on:	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injun Work		28d. Describe	how inju	ry occurred	
	SiO tendi leath. tor: A the fu	cati	2 Accident investigation M		Yes 2 □ No	00(1)	-		
	Division or Attending strer death. I Director: After d in by the fune	ertification:	4 Homicide determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)	ctory, office		City or To		nd Number or Rura 9)	a Houte Number,
	Hospite 4 hours Funera ely fille	edical C	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occur on the basis of examination and/or investigation and manner stated.	rred at the tin ation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s)) and manner as s d place, and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. Licens				te signed (Month,	
	v		I holand	00	0571.	24		12/261	04
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, M.D. 13219 Executive Park	Terra	ace Germ	antown,	MD	20874	
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	park.					
	Regist	rar	DEC 3 0 2004 Server 15 14	pour.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** onn 2002 /Medical 4a. Facility Name (If not institution, give street 4b. City, Town or Location of Death 4c. County of Death Examiner Balnman Shock Trauma If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 030 07 9676 88 Yrs. Director 24 1916 Massachusetts Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylai Department of Health end Mental Hygiene.
Department of Health end Mental Hygiene.
The morbital: If Item 27 is marked other than "natural", or items 23a or 28e-f show many hiury or other treumatic event, the Medical Examiner must be notified at once. Be Completed by Funeral Director Md. Montgomery Sandy Spring 1 ☐ Yes 2 ☒ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20860 17310 Quaker Lane, #C10 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☆Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 No White WWII Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Quality Control Co. 12 0 Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Nickerson Henry Pierce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17310 Quaker Lane, #C10, Sandy Spring, Md. 20860 Marie Pierce / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crem. 12/29/04 * 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Va. 21. Signature of Funeral Service Licensee ^{22. Name and Address of Eacility} Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 15/00 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) arol Hallanns physician and s the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the a be datached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, cate has been signated by page 2 should b 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 1□ Yes Division of Vital 25. Was case referred to medical example? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Bd Describe how injury occurred lived in MVA 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending 5:28 2 Accident eftar death. 1 Yes 2 No investigation 20-2004 the 6 ☐ Could not be Suicide 28f. Location (Street and Number of Rural Route, Number, // City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide OAdu within 24 hours el To the Funeral D complately filled i 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

3+1

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year DEC 30

30. Name and addies;

DHMH 17 Rev 1/2001

29c. License number

and manner stated.

of person who completed cause of death (Item 23a) (Type, Print)

17.45 32. Pégistrar's Signature

			1 - For State Registrar	State of M	laryland /		artment			ind M	lental H	ygien Reg. N	7111	l,	428	87
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, La Rosalind C. Pear Aa. Facility Name (If not institution, give	t)		4b. City, 1	Town, or	Location of	f Death	2. Date of D Month Dec.	24,	ay Y	/ear Death	3. Time of 8:20	Death A ^M
	Funeral Director		8606 Bunnell Dri 5. Social Security Number 579.58.0423		ge (In yrs. last 99	birthday) Yrs.	Poto	mac	If Under 2 Hours	24 Hrs. Min.	8. Date of B (Month, I	Mirth Day, Year	ontgo	mery Birthp	lace (State on try)	r Foreign
	ס	stor	Usual Residence of Decedent 10a. State 10b. County MD Montgon	nery	10c. City, To		cation				NOV . 12	,190	. .		Od. Inside Cit	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show any injury eacher treumetic event, the Modical Examination in a page.	by Funeral Director	10e. Street and Number 8606 Bunnell Driv 11. Marital Status	7E 12. Was Decedent Armed Forces	Ever in U.S.	13. V	10f. Zip	54	spanic Orig	in? (Spe	cify Yes or N Rican, etc.)	US	14. Race -	Americ	an Indian,	-
21215-0036	72 hours after naturel', or it	eted by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gra	1 Tes 2 A If Yes, Give Year or Dates:	No	fa. Deced	☐ Yes 2	No Occupa	Specify:				Specify: V		е	
nd 2121	oe filed within al Hygiene. I other then vent, the Me	Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last	College (1-4or	5+)	life. L	al Ex	ə rətirəd) amin	er		(First, Middl			Gove	ernmen	t
Baltimore, Maryland	nd 2 should bath and Mentaly and Mentaly 27 is marked retreametic e	To f	James Cummings 19a. Informant's Name/Relationship (Lowell D. Peart -		18	9b. Mailin 606 I	g Address Bunne]	(Street as	nd Number	nown or Rura Pot	Route Numi	ber, City	or Town, Sta	ate, Zip	Code)	
Itimore,	artment of Hea artment of Hea ortent: If item injury onhe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)	Ft. Cemet	tery, crem Linco cery	atory or oth	ner place	_ De	ec.30	ate 2,2004	Bre	ocation - Cit	a M	D	
Ba	Dep Dep Impo		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death. D	51	30 Wi	sons	in Av	re. N	eph Gar N.W.,	WDC	's Sor 20016		Approximate Interval Betw	reen
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	b. Arterio	a consequenco sclero	e of): tic H									Onset and D Immedia	ate
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence											
.O. Box 6	that the death certificated by the attending posterior of detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√2 No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pred Other (spe						23d. Date o Month			ear
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions of Chronic Obstruct					use giver	n in Part I.						e cause of de	
Vital Rec		Se Completed	25. Was case referred to medical						26 Place o	of Death	24a. Was auto perfo 1 Yes	psy ormed? 200 No	prior	r to com th?	sy findings avipletion of cau	vailable use of
Division of V	ding Phys h. After this funeral di	ation: To B	examiner? 1 🛣 Yes 2 🗌 No 27. Manner of Death 1 🐼 Natural 5 🗍 Pending 2 🗒 Accident investigation	Hospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da		Outpatient Time of Injury	3 DOA 286	Other c. Injury a Work?	4 🗌 Nurs	sing Hom	e 5 🔀 Res 8d. Describe	idence		Specify		
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	To the Hospitel within 24 hours a To the Funerel Completely filled	Medicai	29b. Signature and title of certifier	ysicien: To the best niner: On the basis of and manner sta	i examination a	and/or inve	estigation, in	n my opir	nion, death	occurred	at the time,	date and	and manned place, and te signed (M	due to	the cause(s)	
	6		30. Name and address of person who	completed cause of d	m (Item 23a) (Type, P		D245	43			Dec	ember	28,	2004	
ľ	Sta Registr		James A. Rossi, 31. Date filed (Month, Day, Year) DEC 3 0 200	32 Registra	5 North ar's Signature	Lei	sure l		d Blv	d.,	Silve	s Spi	ring,	MD	20906	

			For State Registrar	State of M	aryland / Dep		Health an	d Mental H		004	42888
İ	Physici	an	Decedent's Name (First, Middle, L		D-44			2. Date of I Month	Day	Year	3. Time of Death
	/Media	al	Chauncey 4a. Facility Name (If not institution, g.	Harris	Patters		n, or Location of D	Daca	_	3), 200	
	Examin	er	132 Blue Bill C		,		e De Gra			Harford	
-	Funeral			Sex 7. A	ge (In yrs. last birthday,		ar If Under 24				place (State or Foreign
	Director		579-26-8183	1 M 2□F	77 Yrs.	MOTHERS	ys Hours	01-14-	-1927	Wash	ington, DC
	and and		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	Mary f sho	to	MD Harfo	rd	Havre D	e Grace				1	XXYes 2□No
	h the	irec	10e. Street and Number			10f. Zip Cod	0			n of What Cou	intry?
	23a	rai	132 Blue Bill (2107			U.S		
36	72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show alcal Examinating the Hullifud at	by Funeral Director	11. Marital Status 1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 XYes 2 If Yes, Give Year or Dates:	No 1945-46	Was Decedent of Yes, specify 0		? (Specify Yes or I Puerto Rican, etc.)		Black, White Brocify: Wh	
9500-61212	2 hou		15. Decedent's	Education	16a. Dece	dent's Usual Oc	cupation	Luarkina	16b. Kind	d of Business/Ir	ndustry
7	F 8 8 1	Completed	(Specify only highest g	College (1-4or	5+) life.	DO NOT use re	,	working	Λ	Mation	al Cuand
	filed will Hygien other the	Cor	12 17. Father's Name (First, Middle, Las	<u></u>	010	il Engi		Name (First, Midd			al Guard
Maryland	be d la la la la la la la la la la la la la) Be	Chauncey H. Pat					thy Speal		umame)	
چ	should by	T ₀	19a. Informant's Name/Relationship		19b. Mail	ing Address (Str		or Rural Route Nun		Town, State, Zi	p Code)
	s 1 and 2 should of Health and Mer Item 27 Is marke other traumatic		Barbara S. Patte	erson - Wi				, Havre	De Gra	ce, MD	21078
ore	of He		20a. Method of Disposition 1	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other	place)	Date	20c. Loca	ation - City or T	own, State
Baltimore,	Pag tment tant:		`4 ☐Donation 5 ☐ Other (Spec	rify)	MD_Vetera			10-2005	Chel	tenham,	, MD
g Pa	permit. Pages: Department of F Important: If ite any injury or of		21. Signature of Funeral Service Lic	7			uneral x 156.	done Valdorf,		604	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each	id the death. Do not entine. Com C 37 s a consequence of):	ter the mode of	dying, such as ca	rdiac or respiratory	r arrest,		Approximate Interval Between Onset and Death 2 2 mc
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	s a consequence of):						
1,60,	ata be executed hysiclan and the burial-transit	icai Exar	that initiated events resulting in death) Last	CDue to (or as	s a consequence of):						
O. Box 68	death certific e attending p od for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	st 12 months? 4 Pregnant at time of death 5 Other (specify) Month							
ecords, P	The law requires that the tite has been signed by thouge 2 should be detache	by	Fait II. Other significant conditions continuously to death out not resulting in the underlying cause given in Part.								
I,		Completed							topsy rformed?	24b. Were auto prior to co death? 1 Yes	opsy findings available ompletion of cause of
Vita	Physician: The ribis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Death (Check onl			
o	ding Phys n. After this funeral di	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	28a. Date of Inj (Month, D	ury 2 ☐ ER/Outpatie ury 28b. Time (ay Year) Injury	of 28c. I	Other: 4 Nursi njury at Work? I Yes 2 No	28d. Describ	esidence 6	Other (Speci occurred	<u>fy)</u>
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not determine	reet, factory, offi	се		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in	edical	29a. Certifying (Check only one) Certifying 2 Medical Ex	aminer: On the basis	t of my knowledge, dea of examination and/or in tated.	nvestigation, in m	ny opinion, death	occurred at the tim	e, date and p	lace, and due t	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier Howke	4,170	death (Item 23a) (Type	29c. Lic	ense number	7	29d. Date	signed (Month,	31, 2004
M	P12+1	l la	It Farkas	o completed cause of	death (Item 23a) (Type	Print)	ern U	re suple	ke It	vorice	ElkTon, M
	Sta Regist		31. Date filed (Month, Day, Year)	2005 32. Reg	trar's Signature	Sparke				//	,
DI	HMH 17 Rev 1/2	001									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registra AMEND ITEM #8&20b PERFH C839 G9751119 ate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Edna Ryan 29, /Medical Dec. 2004 A^{M} 10:15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4829 Drummond Avenue Chevy Chase Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 5-1916 9. Birthplace (State or Foreign (Month, Day, Year) 1 □ M 2 🕅 F 506.03.3868 Director 88 Yrs. Nebraska Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d, Inside City Limits 7 is markad other than "natural", or Itams 23a or 28a-f shov traumatic event, the Maxical Examinar anst be nutified at Chevy Chase MD Montgomery Completed by Funeral Director XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 USA 4829 Drummond Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is markad of Thomas Coufal Barbara Mares 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C 19a. Informant's Name/Relationship (Type, Print) Edward Ryan / Husband 4829 Drummond Ave., Chevy Chase, MD f Health item 27 othar Jan 12, 2005 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of njucko Ξ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National perrit. Page Depirtment (Important: If any njury o Jan.5,2005 Arlington, Virginia ^¹ 4 □ Donation 5 □ Other (Specify) Cemetery 21. Signature of Furral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. N.W., WDC 23a. Part1. Priter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 years Immediate Cause (Final disease or condition **Physician** Metastatic Adenocarcinoma of Lung resulting in death) /Medical Due to (or as a consequence of): Examiner Adenocarcinoma of Lung J years Sequentially list conditions Examiner Due to (or as a sonsequence of) cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Completed 1 ☐ Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? 1 Yes 212 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 □ No this 3□ DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred 1 X Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) Medi To the within 2. To the ! 29b. Signa un 29c. License number 29d. Date signed (Month, Day, Year) D21531 December 30, 2004

Registrar

31. Date filed (Month, Day, Year)

JAN 0 3 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter Pushkas, M.D. 11510 016

11510 Old Georgetown Rd., Rockville, MD
32. Poistrar's Signature

25

State of Maryland / Department of Health and Mental Hygien

					Ce	rtificate	of Death		Reg. No.		
	Decedent's Name (Firs	t, Middle, La	st)					2. Date of E	eath Day	Year	3. Time of Death
ysician Madiaal	Anna Mae					anda11			ber 31,		4:30 AM
Medical — caminer ^{4a}	Fecility Neme (If not in	nstitution, giv	e street and nu			andari	4b. City, Town	, or Location of Dea	th 4c. Count	y of Death	14.30 AII
IIIIIII	Allegany (County	Murein	n a & R	ohah Co	ntor	Cumbe	rland	۸.1	10000	
5	Social Security Number				yrs. lest birthday)			Hrs. 8 Date of P	irth A 1	legan	y ace (State or Fore
			□M 2\\ F	77		Months E		Hrs. 8. Date of E (Month, I 03 / 27	Day, Yeer)	Count	ace (State or Fore
1	19-14-7156 sual Residence of Dece	dont						03/2/	/ 1 7 2 /	Mary	land
_		County		100	c. City, Town or Lo	cation				10	od. Inside City Limi
		Alleg.	a n v		•	erland					1 X Yes 2 □ 1
<u> </u>		miles.	111 y		Gumb						
10	De. Street end Number					10f. Zip Co	ode		10g. Citizen of	What Count	try?
Funeral Director	54 1	Mari	on Stre	et			21502		USA		
11	I. Marital Status		12. Was Dec	edent Ever	in U,S. 13.	Was Deceden	t of Hispanic Origin Cuban, Mexican, P	? (Specify Yes or N	lo- 14. Ra	ce - America	
	1 ☐ Never Married 2	☐ Married	1 Yes	orces? 212∑No				uerto Hican, etc.)	Bla	ick, White, e	etc.
	3XDXWidowed 4 □ D	ivorced	If Yes, G	2)∑No ive Dates:		1 □ Yes 24⊡	No Specify:		Specia	fy: T	White
					16a Dece	fent's Usual C	occupation		16b. Kind of B		
	(Specify only	y highest gra	fucation de completed))	(Give	kind of work	done during most of retired)	working	TOD. KING OF E	iusiiiess/iiiu	ustry
17.	Elementary/Secondary	(0-12)	College ((1-4or 5+)	1				11-	1	1
	12					Dietic	-			spital	1
17.	7. Father's Name (First,	Middle, Last)						Name (First, Middl	e, Maiden Sumai	ne)	
	Charles		Ray	mond	${\tt Himm1}$	er	Dolly	. r	Г. К	reger	
	9a. Informant's Name/Re	elationship (Type, Print)		19b. Maili	g Address (S	treet and Number o	r Rural Route Num	ber, City or Town	, State, Zip (Code)
9	Steven Rand	la11 /	son		810	5 Jeff	rey Court	. Fairfa	c Statio	n. VA	22039
	a. Method of Disposition			2				Date	20c. Location		
200	1 □ Burial 2 ☐ Cren	mation 3 🗆	Removal from	State	Ob. Place of Dispo cemetery, crei	natory or othe	r place)	!	l .		
	4 □ Donation 5 □ O	ther (Specifi	1)		Cumberla	na Grei	matory	1/3/200		,	,
21	1. Signature of Funeral S	Service Licen	see		22		ddress of Facility	Adams Fa			,
	1 tolu	*	(1)	1000	4	404 D	ecatur St	reet, Cur	nberland	, MD	21502
_	3a. Part1. Enter the dise shock, or heart failur	10	- 00								Approximate
lm	Immediate Cause (Final disease or condition ENO STAGE CHRISTILE BASTRUCTIVE										
Im dis	Immediate Cause (Final disease or condition resulting in death) a. END STAGE CHRONIC OBSTRUCTIVE Due to (or as e consequence of): LUNG DISEASE									i	
	Due to (or as e consequence of):									1	
Ë			JA .			し	9 No C	DISE	ACE	كرا	3 YRS.
Completed by Physician/Medical Examiner	equentially list condition	s,		Due	to (or es a consec	uence of):				1	
in a	use. Enter Underlying	ite								1	
tha	equentially list condition any, leading to immedia ause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last		C	Due	to (or as a conseq	uence of):				1	
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2			d							-	
Ca							and the State of	an Die			4h
S Par	art II. Other significent o	conditions co	ontributing to a	eath but no	t resulting in the u	iderlying caus	e given in Part I.				the ceuse of deet
듄								10	Yes 2 No	3 Proba	ably 4 ☐ Unkno
<u> </u>								_			
B								24a. Wa	s an autopsy ormed?	avail	e autopsy finding: lable prior to
<u> </u>								-		com of de	pletion of cause eath?
Ē									YUB 24 No	+	
3										'	Yes 2□ No
וב	i. Was case referred to r examiner?	medical	Hospitali					Death Check on	one		
	1 Yes 2 No			-	2 ER/Outpatier			ig Home 5□ Res		1 1 27	
27.	. Manner of Death	Destina	28a. Date	of Injury oth, Day Yea	28b. Time of Injury	28c.	Injury at Work?	28d. Describe	how injury occur	red	
4	1 ☐ Natural 5 ☐ 2 ☐ Accident	Pending investigation		, ou, · o=	,,	М	1 Yes 2 No				
<u> </u>	3 Suicide 6 🗆	Could not be determined	28e. Flace	e of Injury -	At home, farm, str	et, factory, of	fice		(Street end Numb	per or Rural i	Route Number,
5	4 Homicide	ectonininou	buildi	ing, etc. (Sp	pecify)			City or To	wn, State)		
3				400000000000				SPECIAL SERVICE SERVIC	799		
29:	(Check only 2 ☐ M						ne time, date and pl my opinion, death o				
27. 27. 29. 29. 29. 29. 29. 29. 29. 29. 29. 29	one)		and man	ner stated.							
≥ 291	b. Signature and title of	certifier	. () 1		29c. Li	cense number		29d. Date signe	d (Month, Da	ay, Year)
	1/ when	mon	∨ دمیا	/- 八	1119 ~	- I D.	-1486	5	JANO S	100	2005
00	Name and address of	nareon who	ompleted .	se of death	(Item 2) /Tune	1	1100	-	עודוע,	- 1	20
30.	Name and address of p Robu				(Item 23) (Type, M.D.		emorial A	venue. Ci	mherland	d MD	21502
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e			1	legistrar's S		1					
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۵		stiano , Year)	J. Ba	rrera	, M.D.,		emorial A	venue, Cu	mberland	d, MD	2

State of Maryland / Department of Health and Mental Hygiene 1,2891 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ROCK Julius 27, 2004 **Physician** December 11:35 A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 16, 1915 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** New York 1 → M 2 □ F 89 577-10-1690 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10b. County 10a. State ? is marked other then "naturel", or items 23a or 28e-f show treumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2√2 No Directo Bethesda Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20814 5225 Pooks Hill Road #122 N Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours efter 1 ☐ Never Married 2 X Married Specify: white 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4gr 5+) Elementary/Secondary (0-12) Automotive Supply Salesman 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental Hient: If Item 27 is marked other Minnie Pear Hyman Rock and N 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 60 Edgewater Drive, Coral Gables, FL Alan Rock, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 12/29704 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If King David Memorial Garden Falls Church, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home any ir 254 Carroll St., NW, Washington, DC 20012 Approximate Interval Between Onset and Death 23a. Part 1. Finer the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lymphoma **Physician** /Medical Due to (or as a consequence of): Examiner Sepsis with Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Thrombocytopenia The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 2 No certificate Hospitel or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner1 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1X Inpatient į ို 1 ☐ Yes 2 X No this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending 1 Yes 2 No investigation death. 2 Accident ofter death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funerei C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 28, 2004 D 0058965 Khanvay Dama 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11119 Rockville Pike, Suite 100, Rockville, MD 20852 M.D., Saima Khawaja, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 3 0 2004 DEC Registrar

			State of N State of N Registrar	Maryland / De		ment of He		d Mental Hy	giene	Sec 6/ 1/2/	- Down	428	892
	Physici	an	Decedent's Name (First, Middle, Last) Ruth Ann Rochlitz					2. Date of De Month Decemb	eath Da	y Ye	ar	3. Time of	Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number	or)	46	o. City, Town, or I	ocation of D			County of E		7:30	
	LXdIIII	CI	4028 Beltsville Road			Beltsvi	lle		Pr	ince	Georg	re's	
	Funeral Director		5. Social Security Number 6. Sex 7. A 212-32-0511 1 □ M 2 □ F	Age (In yrs. last birtho 72 Yrs	M	Under 1 Year onths Days	If Under 24 I Hours N	Hrs. 8. Date of Bi Min. July 2					or Foreign
	P		Usual Residence of Decedent	10-01-7									
	show	-	10a. State 10b. County	10c. City, Town o		_						Inside Ci	
	Be-f	Director	Maryland Prince George 10e. Street and Number	's Bel	Ltsv:	111e			10- 0'				2 110
36 s after death with the Maryland	with		4028 Beltsville Road			,				izen of Wha	Country	ſ	
	ns 23	eral	11. Marital Status 12. Was Deceder	nt Ever in U.S.	13. Was	20705 Decedent of His	panic Origin?	(Specify Yes or No		USA 14. Race - American Indian,			
	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or Items 23a or 28e-1 show ovent. De Medical Exant ment be notified at	by Funeral	Armed Forces 1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Dates	No.		es, specify Cuban Yes 2 🔀 No	, Mexican, Pi Specify:	? (Specify Yes or No uerto Rican, etc.)		Black, White, etc. Specify: White			
215-0036	2 hou	ed	15. Decedent's Education	16a. De	ecedent'	's Usual Occupat	ion		16b. K	ind of Busine	ss/Indus	try	
2	within 72 ene. than "nat	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40)	(S)	Give kind ife. DO l	d of work done du NOT use retired)	iring most of	working				1	
7	giene giene er the	No.	2		ledic	cal Secr	etary		I I	Medica	1		
<u>B</u>	al Hygid I other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle	, Maiden	Sumame)			
Vlan	2 should be f and Mental F le markad of reumatic eve	70	Joseph J. Rochlitz				Helen	Tice					
Mary	and and le my	u l	19a. Informant's Name/Relationship (Type, Print)	19b. M	Mailing A	ddress (Street ar	nd Number or	r Rural Route Numb	er, City o	r Town, Sta	e, Zip Co	de)	
e, ≥	es 1 and 2 should b of Health and Ment I Item 27 le markac r othar treumatic e		Carol Collins/ Niece					d, Belts					
0	Por of H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from Stat	.0	cremato	ry`or other place,	1	cember 29		cation - City			
altimor	then tent:		`4 □ Donation 5 □ Other (Specify)	Metropoli		Crematory		004	A1	exandı	cia,	Virg	inia
ga	permit. Pages 'Department of himportent: If Ite any injury or of once.		21. Signature of Runeral Service Licensee		Fra	ncis J. Univers	Collin	ns Funera lvd, W, S	l Ho	me Inc r Spri	ng,	MD 2	0901
			23a. Part1. Enter the disease, or comflictions that causshock, or heart failure. List only one cause on each	ed the death. Do not line.	t enter th	ne mode of dying,	such as care	diac or respiratory a	ırrest,		Int	proximate erval Bety iset and D	ween
	Physician /Medical bulkaricien and bulkaricien and stipe private transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying California that initiated events c.	is a consequence of): as a consequence of): as a consequence of):	:	ncer							
.O. Box 68/60	death certii e attending ad for use a	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		opic pregnancy ner (specify)			23d. Date of delivery Month Day Year			'ear		
GS, I	requires that the reen signed by th hould be detache	d by P	Part II. Other significant conditions contributing to death Hypertension	but not resulting in th	he under	lying cause given	in Part I.		obacco u Yes 2[se contribut □No 3	e to the ca Probably		
Hecords	e las has	Completed						24a. Was auto perfo		death	to comple	tion of ca	ivaliable luse of
VII	iclan: Th certificate rector, pag	0	25. Was case referred to medical			1	26. Place of I	Death (Check only of					
>	Phyelclan: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ※ No Hospital: 1 ☐ Inpat	tient 2 ER/Outpa	atient 3	B DOA Other	4 🗌 Nursin	g Home 5 🔀 Resi	dence 6	Other (S	pecify)		
ion oi	nding Phye		27. Manner of Death 1 1 Notural 5 □ Pending 2 □ Accident investigation 28a. Date of In (Month, D	jury 28b. Tim Jay Year) Injur	ігу	28c. Injury a Work? M 1 ☐ Ye	nt es 2 ⊡No	28d. Describe	how injur	y occurred			
DIVISION	To the Hospital or Attending Physician: which 24 hours after death at the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined 28e. Place of It building, 6	ı, street, i					n (Street and Number or Rural Route Number, Town, State)				
	ie Hospit 24 hour ie Funeri letely fill	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis and manner s	of examination and/o	death occ or investi	curred at the time gation, in my opin	, date and pla nion, death o	ace, and due to the courred at the time,	cause(s) date and	and manner place, and o	as stated due to the	i. cause(s)	
	withir To th comp	Me	29b. Signature and title of certifier	CE		29c. License	number		29d. Date	e signed (Mi	onth, Day,	Year)	
	10		frami (eltisss-	Typner	-W	D28	079		D	ecemb	er 29	9, 20	004
	1		30. Name and address of person who completed cause of	death (Item 23a) (Ty	pe, Print	1)							
			Francis A. Higgs-Shipman,					ad, Belts	vill	e, MD	2070)5	
٢	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	1	sporks	/						

			For Stata Registrar		State o	f Marylan	•	artmen rtificate				-	giene Reg. No.	04	42893	
			Decedent's Name (Firs.	t, Middle, La	st)						-	2. Date of De	ath	Year	3. Time of Death	
	Physici /Medio		LYELL HALI	ERITC	HIE							DECEMB			11:02 A M	
	Examir			4a. Facility Name (If not institution, give street and number) CHESTER RIVER HOSPITAL CENTER					4b. City, Town, or Location of Death CHESTERTOWN				4c. County of Death KENT			
	Funeral Director		5. Social Security Number 342-22-7503	3 1	ex ĽXM 2□F	7. Age (In yrs. 7		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da SEPT 2	8,1927	9. Birthp	place (State or Foreign ntry)	
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc.				cation						1	IOd. Inside City Limits		
	the Marylar 28a-f show notified at	į	MD	KENT			CHESTE	RTOWN							1 ☐ Yes 2 📉 No	
	th with the 23a or 28 unit be no	ai Dire	10e. Street and Number 23237 CEDAF	R POIN	Г ROAD			10f, Zip	Code 216	20			10g. Citizen USA	of What Coul	ntry?	
9200-51	72 hours after death with the Maryland natural', or items 23a or 28a-f show diseal Exandrer musi be motified at	by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 D		12. Was Dec Armed Fo 1 (X)Yes If Yes, Gi Year or D	2 □ No ve	in U.S. 13. Was Decedent of Hispanic Origin? (Sprif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:					pecify Yes or No- o Rican, etc.) 14. Race - America Black, White, et Specify: WHIT			etc.	
5-0	"natural",	etec	15. D (Specify onl)	ecedent's Ed y highest gra	ducation de completed)		(Give	dent's Usua kind of wor	rk done o	lurina mos	t of worki	ng	16b. Kind a	f Business/In	dustry	
2121	e filed within I Hygiene. other than "	Completed	Elementary/Secondary	(0-12)	College (1-4or 5+)	1	DO NOT US NCIAL			ANT		FINA	NCIAL		
land 2	ild be filed lental Hygi ked other ic event, i	To Be C	17. Father's Name (First, LYELL HALE			-						(First, Middle CH WOLF		name)		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23s or 28s-1 show may highly or other traumatic event, it is Wedical Explained must be notified at any highly or other traumatic event, it is Wedical Explained must be notified at an ones.	۲	19a. Informant's Name/R ALICE RITCH		* .			•				Route Numb				
Baltimore,				mation 3 🗆		State	Place of Disponentery, created SAPEAK	matory or o	ther plac			29,2004		on - City or To		
Balti	permit. Pag Department Important: any injury o		1 Burial 2 (Acremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility FELLOWS, HEIFENBEIN & NEWNAM FUNERAL HOME, 130 SPEER ROAD, CHFSTERTOWN, MD 21620											HOME, P.A.		
23a. Part 1. Enter the disease, or complication. That caused the death. Do not enter the mode of dying such a shock, or heart failure. List only one cause of chiline. Physician Immedical disease or condition resulting in death)								such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death			
8760,	ate be executed thysician and the burial-transit	dical Examiner	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 5 Other (specify) 23d. Date of Month 23d. Date of Month													
.O. Box 6	certific nding p use as	ysiclan/Mec											23d.	Date of delive Month	ery Day Year	
Q_	wrequires that the death been signed by the atte should be detached for a	d by Ph										23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
of Vital Records,	e las has	omplete	H							<u> </u>		24a. Was auto perfo	an 24 psy ned? 2 No	b. Were auto prior to co death? 1 \(\sum \text{Yes}	psy findings available mpletion of cause of	
ita	ician: Th certificate rector, paç	Be C	25. Was case referred to examined?	medical						26. Place	of Death	(Check only o				
of V	Physician: this certific ral director.	2	1 ☐ Yes 2 ☐ No				ER/Outpatier			4 _ NU		ne 5 Resi			y)	
n c	fler fler	lon:		Pending		of Injury oth, Day Year)	28b. Time o Injury	f 2	8c. Injury Work	at :? /es 2 □		28d. Describe l	how injury oc	curred		
Division	or Attending after death. Director: After In by the fune	Certification:	2 Accident 3 Suicide 6 4 Homicide	investigation Could not b determined	e 28e. Place	of Injury - At he ing, etc. <i>(Specif</i>	ome, farm, st	_		163 2 0		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Ce			niner: On the b	e best of my kno asis of examina iner stated.										
	o the	Me	29b. Signature and title o	certifier				290	. License	number			29d. Date sig	ned (Month.	Day, Year)	
	->-0)	1					m	511	T81	,	12/	29/	04	
			30. Name and address of	person who	completed cau	se of death (ten	n 23a) Type,	Print)	Ro	x (he	sterto	wn	md	21620	
	Sta Regist		31. Date filed (Month, Da			Registrar's Signa	/1	Some	60							

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland / Depa	artment of Health and Martificate of Death		2004	12894	
	Physicia /Medic		1. Decedent's Name (First, Middle, Las. Dikka M. Ri	1) E &		2. Date of Death Month DRL Rmb	Day Year		
	Examin		4a. Facility Name (If not institution, give MONTGOMERY GEN)	street and number)	4b. City, Town, or Location of Death OLNEY		4c. County of Death MONTGOME	RY	
	Funeral Director		4/9-0/-288/	7. Age (In yrs. last birthday) M 2 F 96 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y OCT 29	9. Birtho Court	place (State or Foreign ntry) IOWA	
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD MONTGO	DMERY SANDY S			1	0d. Inside City Limits	
	with the N 3e or 28a-	i Director	10e. Street and Number 18100 SLADE SO	CHOOL RD.	10f. Zip Code 20860	10g	10g. Citizen of What Country? USA		
e, Maryland 2	within 72 hours after death with the Maryland ene. then "naturel", or llems 23e or 28e-f show the Madical Exertinative notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: WH		
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene from them 23e or 28e-f show term 27 is marked other then "naturel", or Items 23e or 28e-f show other traumatic event, the Medical Exar. It at must be notified at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	(Give	dent's Usual Occupation skind of work done during most of work DO NOT use retired) PER LIBRARIAN	ing 1	Sb. Kind of Business/In MONTGOMER LIBRARY S	Y CO.	
	should be filed nd Mental Hygid marked other imatic event, II	To Be Co	17. Father's Name (First, Middle, Last) MARCUS MOEN	31	18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)		
	and 2 should be Balth and Mental n 27 Is marked on traumatic ev		19a. Informant's Name/Relationship (7 ELISABETH MCKE)	Type, Print) 19b. Maili LLAR/DAUGHTER #13	ing Address (Street and Number or Rui NOOITGEDACHT	al Route Number, C DR • , HOU	City or Town, State, Zip JT BAY, S	Code) 7806 • AFRICA	
	Pages 1 and 2 nent of Health int: If Item 27 iry or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Hemoval from State FREDERT	osition (Name of matory or other place) ICK CREMAT. 1/3		oc. Location - City or To		
Balti	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licen	/	2. Name and Address of Facility ILTON FUNERAL P.O. BOX 86, BA	HOME RNESVILI	SE, MD 2	0838	
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or come shock, or heart failure. List only disease or condition resulting in death)	olications that caused the death. Do not en one cause on each line. a	ter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death A day S	
8760,	death certificate be executed e attending physician and d for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dispace of high that initiated events resulting in death) Last	Due to (or as a consequence of): C. Due to (or as a consequence of): d.					
.O. Box 68	death certif e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year		
σ	requires that the de pen signed by the a hould be detached t	by	Part II. Other significant conditions of	cco use contribute to t	_				
I Records	The law ate has b page 2 s	Completed				24a. Was an autopsy performe 1 \(\text{Yes} \) 24	prior to co	opsy findings available impletion of cause of	
of Vital	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2 □ ER/Outpatie	Cthor	th (Check only one)		6.1	
ion of	te la	I	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how		<i>y)</i>	
Division	al or Attendir s after death. al Director: At ad in by the fu	Certification;	3 Suicide 6 Could not by 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	28f. Location (Stre City or Town,	on (Street and Number or Rural Route Number, r Town, State)			
	Hospit 4 hour Funera ely fille	edicai C		ysician: To the best of my knowledge, dea niner: On the basis of examination and/or in and manner stated.					
}	To the within 2. To the complete	Me	29b. Signature and title of certifier	p, m.s.	29c. License number		d. Date signed (Month, Decurber 3		
			30 Name and address of person who	completed cause of death (Item 23a) (Type	Philip Dave Oli	by and	20832		
	Sta Regist		31. Date filed (Month, DIA Narl) 3	2005 32. Redstrar's Signature	house.				

			For State	State of	Marylan		artment of H rtificate of		d Mental Hy	- /		42895	
			Registrar 1. Decedent's Name (First, Middle,	Last)			inoate of	Dodin	2. Date of De		•	3. Time of Death	
	Physicia /Medic		Virginia August			oss			Decemb		90, 200	04 17:19 M	
	Examin	er	4a. Facility Name (If not institution, Fort Washington				4b. City, Town, o		a dc. County of De				
	Funeral			6. Sex 1 □ M 21/21 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Irs. 8. Date of Bi	8. Date of Birth 9. Bir (Month, Day, Year) C		thplace (State or Foreign ountry)		
	Director		224-56-3197 Usual Residence of Decedent	_ A	61				APRIL	11,	1943 VI	RGINIA	
	show	ŭ	VA GLOUCE	CTTD		y, Town or Lo AYES	ecation					10d. Inside City Limits 1 ▼ Yes 2 □ No	
	r 28a-f	rect	10e. Street and Number	291EK	1111	HIES	10f. Zip Code			10g. Cit	izen of What Co		
	ath with	ral D	2274 REDCROSS I	DRIVE			23072	2		UN	NITED STATES		
21215-0036	y within 72 hours after death with the Maryland jiene. r then "natural", or Items 23a or 28a-f show It e Modical Examirat must be notilited at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Dece Armed For 1 Tes If Yes, Give Year or Da	ces? 24⊡ No ∍	n U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ▼No Specify:					14. Race - Ame Black, Whit Specify: B	te, etc.	
5-0	"natur	letec	15. Decedent' (Specify only highest	s Education grade completed)		(Give	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				ind of Business	/Industry	
212	75 75 2 20	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		ERS ASSIS	-/		EDUC	CATION		
Maryland	ed fall	Зe	17. Father's Name (First, Middle, LEARL A. MEEKINS,	•					Name (First, Middle				
	ss 1 and 2 should of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationsh JAMES REDCROSS/						Rural Route Numb E, HAYES			Zip Code)	
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		c c	emetery, crer	sition (Name of matory or other pla EMORIAL GAI		N. 5, 2005		ES, VIF		
Balt	permit. Page Department of Important: if eny injury or once.		21. Signature of Funeral Service LYDIA C. THO		INSON	22	THORNTON® 3439 LIVI	FUNERAL NGSTON	HOME, P	.A. DIAN	HEAD, 1	MD 20640	
г			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Development of the complete o										
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	sclero		rdiovascu	ılar Dis	sease			Oliset and Death	
	Examiner		Sequentially list conditions,	b	or as a conseq	derice or _j .							
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a conseq	uence of):							
o,	icate be executed physician and s the burial-transit	Exar	that initiated events resulting in death) Last	C. Due to (d	uence of):								
68760,	cate be	dical		d									
P.O. Box 6	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	,			23d. Date of delivery Month Day Year						
	quires that n signed b uld be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
Vital Records,		Completed							24a. Was auto perfo		prior to death?	utopsy findings available completion of cause of	
Vita	Physician; Tribis certifical	Be	25. Was case referred to medical examiner?	Hospital:	**		Dill		Death (Check only	one)		=	
o	ding Phys h. After this funeral dii	n: To	XXYes 2 □ No 27. Manner of Death	28a. Date o		ER/Outpatien 28b. Time of		4 INUISING	Home 5 Resi 28d. Describe			cify)	
sion	or Attending ifter death. Director: Aftel in by the fune	atlo	Y⊠Natural 5 ☐ Pending 2 ☐ Accident investiga	ation	i, Day Year)	Injury		k? Yes 2 □ No					
Division	i or Attenc after death Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 286. Place	of Injury - At ho g, etc. <i>(Specif</i>)		eet, factory, office		28f. Location (City or To			ural Route Number,	
-	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical Co	29a. Certifier (Check only one) Certifying Medical E	Physician: To the laxaminer: On the ba	sis of examina	wledge, death tion and/or inv	n occurred at the tire restigation, in my o	ne, date and pla pinion, death oc	ace, and due to the courred at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)	
	To th within To th compl	Me	29b. Signature and title of certifier				29c. Licens				e signed (Monti		
)			,	i, mid				C.M.E.			ary 02,		
3	Ple		30. Name and address of person w					et, Bal	timore, 1	Mary.	land 21	201	
	Sta Registr	_	31. Date filed (Month, Day, Year). JAN 0	3 2005 32. Re	strar's Signa	ture /	Joseph						

		1 _ State	State of Maryland		rtment of Herificate of L			giene 004	42896		
		Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Time of Death		
Physic		Janet A. Rowe					Dec.	26, 2004	10:15 p ^M		
/Med Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth									
		653 Wheatmill Cou				lersville		Anne	Arundel		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la.	st birthday)_ Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jul. 8,	(, Year) 9. Bi	rthplace (State or Foreign ountry)		
Director		186-24-9898 Usual Residence of Decedent	M 20XF 72	115.			Jul. 8,	1932	PA		
land ow		10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits		
Many -1 sh	tor	MD Anne Aru	ndel	M	illersvi	lle			1 ☐ Yes 2X No		
h the	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What C	ountry?		
death with the Maryland ms 23s or 28s-f show Croust be notified at	a D	653 Wheatmill Cou	rt West		2	1108		USA			
ING Z IZ 13-UU30 be filed within 72 hours after death with the Marylan ttal Hygiene. d other than "natural", or Items 23a or 28a-f show avant, the Mcdical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 M No If Yes, Give Year or Dates:		/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Wh	14. Race - American Indian, Black, White, etc. Specify: White		
2 hou	ted	15. Decedent's Educ		16a. Decede	ent's Usual Occupa	ition	rina	16b. Kind of Busines			
hin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired,)	9	Severna P Baptist C			
od wit	Con	12			Bookkee		.=				
IZONO III De file Mental Hy rked oth	Be	17. Father's Name (First, Middle, Last) Henry Frank	Maiden Sumame)								
d Me	2	19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Mailing	Address (Street a	and Number or Rui	ral Route Numbe	r, City or Town, State,	Zip Code)		
S a si		Cynthia A. Palmer	/Daughter	653	Wheatmil:	l Court V	West, Mi	llersville	, MD 21108		
D - 1 2 2		20a. Method of Disposition	20b. Pla	ace of Dispos	ition (Name of atory or other place	e) Dec.	Date 29	20c. Location - City of			
MOF Pages nent of int: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State WOO	dlawn	Memorial	20	29, 004	Harrisburg	, PA		
Baltimor permit. Pages Department of Important: If It any injury or o		21. Senature of Funeral Service Litters	Tella -			sons, P.	A. Seve	rna Park F rna Park,	uneral Home MD 21146		
		23a Parti. Enter the disease, or complication of shock, or reart failure. List only on	cations that caused the death.						Approximate Interval Between		
) Physician		Immediate Cause (Final disease or condition	Advance	1 4	12hoi	mor 5	d	mentia	Onset and Death		
/Medica	l &	resulting in death)	Due to (or as a conseque	ence of):	1 (1)	1141		Alexin	Jean		
Examine		Sequentially list conditions.									
Sit 9d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):							
and and t-trans	хаш	that initiated events cresulting in death) Last	Due to (or as a conseque	ence of):							
8760, cate be executed physician and the burial-transit											
phys s the	edical										
Records, P.O. Box 68/60, The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the buriat-transit	N/M	IF FEMALE: 23b. Was decedent pregnapt 2	3c. If yes, outcome of pregnan					23d. Date of delivery			
death death death death	Physician/M	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{DNO} \)	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year		
by the	hys	9 ☐ Unknown	9Ll Unknown								
15, P.O.	by P	Part II. Other significant conditions con	tributing to death but not result	Iting in the un	derlying cause give	en in Part I.			to the cause of death?		
Records, he law requires t e has been signe ige 2 should be o	led	probable	Dreast	Cal	ncer		1 ∐ Y	′es 2□No 3□!	Probably 4 Minknown		
Aecc se law re se law re se 2 sho	ple						24a. Was a autop	sy prior to	autopsy findings available completion of cause of		
	Completed						perfor 1 ☐ Yes	rmed? death? 2 DNo 1 □ Ye			
f Vital Re ysicion: The l is certificate ha	Be (25. Was case referred to edical examiner?			0.1		th (Check only or	ne)			
Of V Physic this o	2	1 ☐ Yes 2 ☐ No	*	ER/Outpatient		4 🗆 Nursing n		lence 6 Other (Sp	ecify)		
on C	lon	27. Manner of Death 1 Panatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl		280. Describe in	now injury occurred			
Division of tor Attending Phy after death. Director: After this in by the funeral d	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hor	me farm stre		.03 2	28f. Location (S	Street and Number or I	Rural Route Number,		
Div	Certification:	4 Homicide determined	building, etc. (Specify,				City or Tow	vn, State)			
Division of Vita Volta with Residual Proprietien: To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the tuneral director.	edical C	(Check only 2 Medical Exami	sician: To the best of my knowner: On the basis of examinati	viedge, death ion and/or inv	occurred at the tin	ne, date and place pinion, death occu	, and due to the o	cause(s) and manner date and place, and di	as stated. ue to the cause(s)		
thin 2 the I	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	a number		29d. Date signed (Mo	nth, Day, Year)		
T W S				- M	D D:	50720	-	12-27	- 2004		
-		30. Name and address of person who co	moleted cause of death (Item	23a) (Tune	Print)		,	10 01	30-7		
		Jenn For Kion	10gar 860	1 Vo.	terons t	two No	Merci	illo Mo	1) 21108		
* S	tate	31. Date filed (Month, Day, Year)	32, Redistrar's Signat	ture	back :						
Regis		DEC 2.9.7	1004	A A							

SEESE

WILLIAM

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death Month

DEC.

27,

2004

PRINCE GEORGES

14. Race - American Indian.

WHITE

Black, White, etc.

PA.

4c. County of Death

U.S.A.

Specify:

7:00 A M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

6 YEARS

1 Yes 2 □ No

Examiner INDEPENDENCE COURT HYATTSVILLE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months 1**▼**M 2□F Yrs **Director** 301-18-7177 AUG. 15, 1910 Usual Residence of Deceden permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or Itams 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location any injury or effer treumatic evant, the Medical Evandrational Le milliad at MD. PRINCE GEORGES HYATTSVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5821 QUEENS CHAPEL RD. 20782 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 2 No f Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No þ Specify: 3 ₩ Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 WELDING ENGINEER GOODYEAR AEROSPACE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 WILLIAM HOEFECKER JUNE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA DUNN/DAUGHTER 3403 STANFORD ST., ADELPHI, MD. 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY | 12-30-2004 RIVERDALE, MD. 21. Signature of Funeral Service Ligensee Name and Address of Facility ODC9 CHAMBERS FUNERAL HOME & CREMATORIUM, P.A nambus **M00091** 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final **Physician** ALZHEIMER'S DISEASE resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed burial-trans and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe certificata 1 🗌 Yes 2**X** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

ASSISTED

LIVING 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of Natural After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident within 24 hours after deat To the Funerel Director; 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1. Decedent's Name (First, Middle, Last)

MARVIN

4a. Facility Name (If not institution, give street and number)

Physician

/Medical

1160 VARNUM ST. N.E. #021, WASHINGTON, D.C. 20017

29d. Date signed (Month, Day, Year)

23d. Date of delivery

1 🗌 Yes

Dav

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Year

Month

State Registrar

one)

29b. Signature and the of certifier

31. Date filed (Month, Day, Year)

MARIA

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

2005

FAROOQI, M.D.

32. Pogistrar's Signature

DHMH 17 Rev 1/2001

29c. License number

MD33052

		1 - For State Registrar	State of Maryla	ind / Dep	artment of He	ealth and N	•	•	42898
Physi		Decedent's Name (First, Middle,	Last)				2. Date of Death Month	Day Year	3. Time of Death
/Med Exam		Miriam Shapiro 4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or L	ocation of Death	December	26, 200 4c. County of Dea	4 I
		Bedford Court 1 5. Social Security Number		s. last birthday		r Spring		Montgon	
Funera Directo		578-48-3764 Usual Residence of Decedent	1□ M 2□ X 88	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y Mar 18,	1916 N	thplace (State or Foreign ountry) Iaryland
deeth with the Maryland ms 23a or 28a-f show	-	10a. State 10b. County		City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 No
pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Departition of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational be notified at more of the contract of the marked other traumatic event.	Director	Maryland Mont	gomery S	ilver S	Spring 10f. Zip Code		100	J. Citizen of What Co	
th with 23a or	ai DI	13507 Sherwood	Forest Dr		20904	,		USA	outhry :
ar dee items	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,		pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
ified within 72 hours after Hygiene. Ither than "natural; or ite ant, the Medical Examina	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 24 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	IIIh d to
72 hours aff	Completed	15. Decedent's	s Education grade completed)	16a. Dece	dent's Usual Occupati e kind of work done du DO NOT use retired)	ion ring most of work	kina 16	b. Kind of Business	White Vindustry
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i Hygin other	S S	12 17. Father's Name (First, Middle, L	ast)	_ _Home	maker	8. Mother's Nam	e (First, Middle, Ma	Own Hom iden Sumame)	ie
yland ould be file Mental Hy arked oth	To B	Frank Kallinsky	7			Ida Fo	land		
d 2 sho d 2 sho th and th and 17 is m traum		19a. Informant's Name/Relationsh			ing Address (Street and				
THealt Item 2		Mildred White/I 20a. Method of Disposition	20b	Place of Disp	osition (Name of			ver Sprin c. Location - City or	g, MD 20904 Town, State
Definition of the more of the	9	1 X Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (Sp			matory or other place)	1	ec 28, 20	04 Falls	Church, VA
erriit. epartn nporta ny inju		21. Signature of Funeral Service L		2	2. Name and Address	of Facility Hi	nes-Rinal	di Funera	1 Home
0 005 8 0	SI .	23a. Part1. Enter the diseas or	Wormed that any and the de						ng, MD 20904
Physiciar /Medica	_	shock, or heart failure. List of the shock is the shock of heart failure. List of heart failure. List of hea	a Conges	tive He	eart Failur		or respiratory arrest	· 	Approximate Interval Between Onset and Death 2 years
Examine			Due to (or as a conse		uctive Pul	monary	Dicasca		5 years
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certificate be executed ding physician and ise as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):					
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rtificating phy as the		IF FEMALE:	0.						
death death e atter	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	tal déath 3[□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
d by th	Phys	9 Unknown	9 Unknown	and the same			00 0:444		
w requires that the been signed by the should be detached	ed by	Part II. Other significant condition Hypertension	s contributing to death but not re	esuiting in the t	inderlying cause given	in Part I.			o the cause of death? Tobably 4 [Winknown]
e con a law n	Completed	Atrial Fibrilla	tion				24a. Was an autopsy	prior to	utopsy findings available completion of cause of
VICAL DEC SICIAN: The law certilicate has b irector, page 2 s		05 W					performe 1 Tes 2 L		2 No
Physician: r this certificated director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie			h (Check only one) ome 5 Residenc	a 6 TOther (See	0.6.1
ding Phys	D: T	27. Manner of Death 1 XNatural 5 Pending	28a. Date of Injury	28b. Time o	of 28c. Injury a Work?	t t	28d. Describe how	injury occurred	chy)
or Attending of Attending siter death. Director: After in by the fune	ertification:	2 Accident investigated investigated as Suicide 6 Could not	ation			s 2 No	201 1 12		
al or Att	ertif	4 ☐ Homicide determin		nome, ramn, st	reet, factory, office		City or Town, S	et and Number or Ru State)	ural Route Number,
To the Hospital or Attendition 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier 1 Certifying (Check only ona) 2 Medical 8	Physician: To the best of my ki xaminer: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the time, evestigation, in my opin	, date and place, nion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
To the comp	Me	29b. Signature and title of certifier	2 20. 50	Λ	29c. License n	number	29d.	Date signed (Mont	h, Day, Year)
5		James -	TONCON WY	9 X10	D3084	4		December	27, 2004
		100	the completed calls of deat (Ite	1 11	•	Db #/.	00 Paal	dla MD	20850
s	tate	31. Date filed (Month, Day, Year)	icMurray, Jr. M. 32. egistrar's Sign	nature 1	KOCKATITE	: rK, #4	o, KOCKV	TITE, MD	20030
Regis		JAN 03	2005 Bereva	15 19					

	1	For State Registrar	State of Ma		-	rtment of He tificate of L			giene Rog. No	UUU	2899
Physiciar /Medica	١	I. Decedent's Name (First, Middle, Last) Anne Silverman						2. Date of De Month December	Day	7, 2004	3. Time of Death 1:45 P.M
Examine	r	la. Facility Name (If not institution, give s 7420 Westlake Terri		410		4b. City, Town, or Bethesd		ath	1	County of Death	Y
Funeral Director		121-09-0373	7. Age M 2 ☑ F	(In yrs. last birti	hday) (rs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi	n. (Month, Da		9. Birthpl Coun	
Aaryland f ehow	-	Usual Residence of Decedent 10a. State 10b. County Maryland Montgomer		10c. City, Town Bethes		eation				11	0d. Inside City Limits 12 Yes 2 □ No
with the Manual transfer or 28a-		10e. Street and Number 7420 Westlake Terra	acc Apt /	110		10f. Zip Code 2081	7			izen of What Coun	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itsm 27 Is marked other than "natural", or Iteme 23a or 28a-1 ehow any injury or other traumatic event, the Wedfoul Exam for unable coulding all pages.	by Funeral		2. Was Decedent Ender Armed Forces? 1 Yes 27 No lif Yes, Give Year or Dates:	ver in U.S.	If	1	spanic Origin?	(Specify Yes or No erto Rican, etc.)		14. Race - America Black, White, & Specify: White	an Indian, etc.
within 72 hou ene. than "natura	ompiered	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	-)	(Give k	ent's Usual Occupa rind of work done d O NOT use retired)	uring most of w	rorking		ind of Business/Ind	al Service
I be filed ntal Hygi	De C	17. Father's Name (First, Middle, Last) Israel Rosenthal						ame (First, Middle,	Maiden		ar bervice
2 should and Mei Is mark aumatic	2 .	19a. Informant's Name/Relationship (Typ					nd Number or I	Rural Route Numbe	er, City o	or Town, State, Zip	
es 1 and of Health Fitsm 27	-	William Silverman/		20b. Place of cemeters	Dispos	ition (Name of atory or other place	Dec	c, Chevy (ember 27		e, MD 208 pocation - City or To	
nit. Page sartment ortant: If injury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service License		Georget	il WE	univers. Lenter	ity	2004		hington,	D.C.
Per Per Per Per Per Per Per Per Per Per		23a. Part1. Enter the disease, or complic	Sala de	the death. Do n	P.	U. BUX 3	ouu / wa	Service: shington	, D.	nc. 20037	Approximate
Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ISCHE	e.	(ARTOO			rest,		Interval Between Onset and Death
Examiner or and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Exter Urdentials Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o							
icate be executed physician and sthe burial-transit	edicare	d							-		
= m a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death		Ectopic pregnancy Other (specify)				23d. Date of deliver Month	ry Day Year
quires that the signed by all the detail	ò	Part II. Other significant conditions con	tributing to death but	t not resulting in	the un	derlying cause give	n in Part I.	23e. Did to		use contribute to the	e cause of death?
The law requii	Сотріете	<u> </u>						24a. Was autop perfo 1 Yes		prior to con death?	psy findings available apletion of cause of
ysician is certifu director	10 De	25. Was case referred to medical examiner? 1 Yes No	ospital: 1	t 2 ER/Out	patient	3□ DOA Othe		eath (Check only of Home 5 Fesion		6 □Other (Specify)
ath.	ertification;	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred								
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, far (Specify)	m, stre	et, factory, office		28f. Location (\$ City or Tox	Street an n, State	d Number or Rural)	Route Number,
he Hosp n 24 hou he Funei pletely fil	edical	29a. Certifier (Check only one) 12 Certifying Phys 2 Medical Examin	ician: To the best of er: On the basis of e and manner state	examination and	death Vor inve	occurred at the time estigation, in my op	e, date and place inion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner as sta d place, and due to	ated. the cause(s)
To the within to the complex c	2	29b. Signature and title of certifier Alpenal	mave	i Mo	D -	29c. License	number 7 6 6 0	1	29d. Dat	te signed (Month, E	Day, Year)
2		30. Name and address of person who con ALPANA GUZWAN	mpleted cause of de	ath (Item 23a) (Type, F	Print) EVILLE	PILLE,	RU, MI			
State Registra		31. Date filed (Month, Day, Year)	32. Pigistrar			nets?					

			1 - For Stata Ragistrar	State o	of Marylar		artment of H rtificate of L				ene 0 0 !	-}	42900
	Physic /Medi		Decedent's Name (First, Middle, I	Last) ETHEL	SM	IITH			2	. Date of Death Month		^{'ear} 04	3. Time of Death 12: 55P M
4	Examir		4a. Facility Name (If not institution, Suburk	give street and nu			4b. City, Town, or Betl	nesda	a		4c. County of Mont	Death	·
	Funeral Director		5. Social Security Number 060-54-5417 Usuel Residence of Decedent	5. Sex 1 □ M 2 □ M =	7. Age (<i>In yr</i> s. 74	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 6	Date of Birth	3°,1930°	Soun	lace (State or Foreign tryCarOlina
	Maryiand a-f show	tor	10a. State 10b. County Md Montgo	omery	10c. Ci	ty, Town <i>or</i> Lo Roc	cation kville					10	0d. Inside City Limits 1 1 Yes 2 □ No
	th with the 23a or 28a	al Director	10e. Street and Number 725 Monroe	Street	#203		10f. Zip Code 2085	50		100	g. Citizen of Wha		try?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Ptygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notitied at once.	by Funeral	11. Marital Status 1☆ Never Married 2 Married 3 Widowed 4 Divorced	Armed Fo	2 ∕∑ N <i>o</i> ve	1	Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2☐No	spanic Orig n, Mexican Specify:	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)	14. Race -	America White, 6	etc.
21215-0036	within 72 ho ene. than "natur the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		1-4or 5+)	(Give life. L	dent's Usual Occupa kind of work done of DO NOT use retired, MPloyed	ation luring most	of working	16	Sb. Kind of Busin		
Maryland 2	2 should be filed n and Mental Hygi is marked other raumatic event, I	To Be Co	None 17. Father's Name (First, Middle, La Joe Smith	ŕ		0110.	p.royea			First, Middle, Ma	uden Sumame)		
	l and 2 sho lealth and I im 27 is me ther traums		19a. Informant's Name/Relationship (Type, Print) EVelyn Holback (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zipe Town, Stat										20850
Baltimore,	it. Pages intment of hintant: If ite		Evelyn Holback (Sister) 725 Monroe St, #203 Rockville, Md 20 20a. Method of Disposition **Disposition (Signature) 2 Date 2 Occupantion 3 Removal from State 4 Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) Gate Of Heaven 1/8/05 Silver Spring Control of Con										
Ba	permi Depa impo any ir		23a. Part1. Enter the disease, or of shock, or heart failure. List of	Lugar	Aused the deat	1/1/22	46 N. Wa	shir	gtor	St, F	P.A. 20850 Rockville, Md		
	Pnysician /Medical		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a		MYOC	ARDIAL 1						Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b	HYPOX	IA							days
68760,	ficate be executed physician and s the burial-transit	ai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (ST'ROKE Due to (or as a consequence of): PNEUMONIA							days DAYS	
Box 687	death certificate e attending phy ed for use as the	n/Medical	IF FEMALE: 23b. Was decedent pregnant		come of pregna						23d. Date of	fdeliver	
P.O. B	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 ☐ Feta ant at time of d own		Ectopic pregnancy Other (specify)				Month		Day Year
Records, I	The law requires that the ate has been signed by the bage 2 should be detache	by	Part II. Other significant conditions	s contributing to de	eath but not res	ulting in the un	derlying cause give	n in Part I.					bly 4 Unknown
al Rec	ician: The law certificate has b rector, page 2 st	e Completed	25. Was case referred to medical						_	23	d? prior	to com	sy findings available pletion of cause of
Division of Vital	ng Phys fter this ineral di	To B	examiner? 1 □ Yes 2 No 27. Manner of Death 1 No Pending	28a. Date of		ER/Outpatient 28b. Time of Injury	3□ DOA Other 28c. Injury Work	n 4 □ Nurs at	sing Home 28d	5 Residence. Describe how i	e 6 Other (S	Specify)	
Divisio	2017	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place	of Injury - At ho	ome, farm, stre	M 1 □ Y et, factory, office	es 2□N		Location (Stree City or Town, S	et and Number of State)	r Rural i	Route Number,
	To the Hospital of within 24 hours all To the Funeral Completely filled in	Medical	one) 2 Medical Ex	Physician: To the eminer: On the ba and mann	isis of examinal	wledge, death tion and/or inv	occurred at the time estigation, in my opi	nion, death	place, and occurred	due to the caus at the time, date	e(s) and manne and place, and	r as stat due to t	ed. he cause(s)
	2 Wilth	2	29b. Signature and fittle of pertition				29c. License	395			Date signed (M		
			30. Name and address of person who seem to see the seem of the see	-(NO V	M) 3	812 W	endy Lar	ne, S	Silve	er Spri	ng, Mo	1 1	20906
	Sta Registr			2005	gistrar's Signa	K Ap	we						

State of Maryland / Department of Health and Mental Hygiene 🕦 🕕 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) **Physician** DECEMBER 29, 2004 6:10 A В. STEIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) OCT 24, 191 9. Birthplace (State or Foreign Country) PENNSYLVANIA 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M 2 □ F **Funeral** Yrs. 1918 86 371-16-6970 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28e-f show other treumatic event, it e Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director MONTGOMERY SILVER SPRING MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 3310 N. LEISURE WORLD BLVD., #315 20906 UNITED STATES Items 23e death Funera 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) a filed within 72 hours after d il Hygiane. other than "neturel", or Item Black. White, etc. 1 ⊠Yes 2 □ No If Yes, Give WWII Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: δ 3 ₩idowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MERCHANT PRINT SHOP other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill and Mental H Be **ESTHER** GLASSGOLD STEIN DAVID 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh
Department of Health and
Importent: If Item 27 Is rr
eny injury or other treurr
once. 2445 LYTTONSVILLE ROAD, #1100 SILVER SPRING, MD 2091 TOBY A. WOLF, DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 X Removal from State KING DAVID MEM. GDN. | 12/31/2004 FALLS CHURCH, VIRGINIA 4 □ Donation 5 □ Other (Specify) EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signature of Funeral Service Licenses Donald 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 sttlemyer 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Priysician /Medical Due to (or as a consequence of) **Examiner** PERIPHERAL VASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician P.O. Box 68760 certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year for 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown ò signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown cate has been sig , page 2 should b SEVERE CARDIOMYOPATHY Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 💢 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1X Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After 5 Pending investigation 1 X Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0052069 DECEMBER 29, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10313 GEORGIA AVENUE, #306 SILVER SPRING, MD 20902 JULIE KRIVY, M.D., Registrar's Signature 31. Date filed (Month, Day, Year) JAN 03 2005 State Registrar

			1 - For State of Maryland / Dep. Registrar Ce	artment of Health and Mertificate of Death	ental Hygier	Z	42902	
			Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death	
1	Physici /Medic		Margaret McMurray Swanson		December	27,2004	4:00A [™]	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	4c. County of Death		
	Funeval	4	Casey House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Yea	Montgome 9. Birthp	lace (State or Foreign	
١.	Funeral Director		217-80-9599 1□M 2XIF 90 Yrs.	Months Days Hours Min.	Nov. 26, 15	er) Cour 1914 Vii	rginia	
	pug *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le	ocation		1	0d. Inside City Limits	
	Maryli f sho	ţ	MD Montgomery Rockvil	le			1 ☐ Yes 2 ☐ No	
	n the	lrec	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Cour	ntry?	
	23a c	ralD	11212 Farmland Drive	20852		USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Iteme 23s or 28s-f show any injury or other treumatic evant. It. Medical Examinations must be notified at once.	by Funeral Director	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto II ☐ Yes 2X No Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	etc.	
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	filed w Hygiel ther ti		5 Adm. 17. Father's Name (First, Middle, Last)	inistration 18. Mother's Name	(First, Middle, Maide		ommision	
Maryland	ould be Mental Marked o	To Be	Clarence M. McMurray	Priscilla	n Moore			
Mar	d 2 sh th and ?7 is rr treum	П	1 1 21 1 2	ing Address (Street and Number or Rura 212 Farmland Drive			·	
	s 1 an f Heal item 2 other		20a. Method of Disposition 20b. Place of Dispo		-,-	Location - City or To		
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Salti	permit. Departnimporte any inju		21. Signature of Funeral Syrvice Licensee	2. Name and Address of Facility Old	Town Ful	neral Cho	ices	
	\$0.5 a		23a. Part T. Enter the disease, or complications that caused the death. Do not en	205 Belle Haven R		ndria, Vi	rginia22307 Approximate	
	Pnysician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End Stage Chronic Due to (or as a consequence of):			ase	Interval Between Onset and Death 4 years	
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.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ory Day Year	
<u>α</u>	res that the igned by be detact	y Pł	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco	o use contribute to th	ne cause of death?	
ord	w require been sig should b	ted	Congestive Heart Failure		1 Tes	2XNo 3□Prob	ably 4 □Unknown	
Il Records,		Completed			24a. Was an autopsy performed?	prior to cor death?	psy findings available πpletion of cause of 2 Π Νο	
Vita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	the second secon		- 24	
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ivis	I or Attending Phi after death. Director: After thi I in by the funeral.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, sti building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta		l Route Number,	
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical Ce	29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, deat 2 Medicel Examiner: On the basis of examination and/or in and manner stated.					
	o the	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, i	Day, Year)	
)	, L		I Chiki grapel	BR 4216114	Dec	cember 2	7,2004	
	17		30. Name and address of person who completed cause of death (Item 23a) (Type, Dr. Chitra Rajagopal, MD 18111	Print) Prince Philip Driv	ve Olnev.	Marylana	20832	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 3 2005 32. Tegistrar's Signature	Prince Philip Driv				

04-08477 luardo Gustavo Salazar, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	State of Maryland / Department of Heal State Unpend Item 23a,27,28a-f per me 6839 1-18 042	Ith and Me ath as	ntal Hygie	ne No2004	4290
Physiciar		Decedent's Name (First, Middle, Last)		Date of Death	31, 2004	3. Time of Death 13:41
/Medica		Eduardo Gustavo Salazar, Jr.		ecember		13:41 %
Examine		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loca 3340 St. John's Lane Ellicott	City		4c. County of Death Howard	
Funeral Director		212 27 3989 1 Marita Days Ho	ours Min.	Date of Birth (Month, Day, Ye Apr 2, 1	ear) Coul	place (State or Foreig otry) /Land
and and	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				Od. Inside City Limits
Mary -f she	টু	MD Howard Ellicott City				1 ☐ Yes 2 ☐XNo
or 286-1 show	rec	10e. Street and Number 10f. Zip Code		10g.	. Cilizen of What Cour	ntry?
23a o	a D	3340 St. John's Lane 21042			United Sta	ates
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of He		20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place)	Dat		c. Location - City or To	
Page nent ent: h		'4 □ Donation 5 □ Other (Specify) St. Louis Cemetery	1-5-2	005 Cl	arksville,	MD
permit. Pages 1 ar Department of Hea Importent: If Item any injury or othe		21. Signature of Funeral Service Licensee W01044 22. Name and Address of Funeral Service Licensee 4112 Old Colu				
cate be executed by sicion and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):				
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or Attending after death. Director: After d in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide 1 X Could not be determined 2 Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found at home	28	f. Location (Street City or Town, St	tand Number or Rura tate) 3340 St. City, Md	l Route Number, Johns Lai
nounound in the state of the st	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, da my Medicel Exeminer: On the basis of examination and/or investigation, in my opinion and manner stated.	ate and place, an	d due to the cause	e(e) and manner as s	ated. the cause(s)
To the Ho within 24 To the Fu completel	Me	29b. Signature and title of certifier 29c. License num	nber	29d.	Date signed (Month,	Day, Year)
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03		31. Date filed (Month, Day, Year) 32. Signature	Baltimor	e, Maryl	land 21201	
State Registra		JAN 0 4 2005 Street St. Smartes				

			For State Registrar	State of	Maryland	-	artment o			ental Hy	giene () 4	42904		
	Dharaini		1. Decedent's Name (First, Middle	Last)						2. Date of De Month	eath Day	Year	3. Time of Death		
	Physici /Medi		Gladys Virgi							Decemb		2004	12:35 ^{p м}		
	Examir	ner	4a. Facility Name (If not institution,						ation of Death			y of Death			
			Calvert County 5. Social Security Number	Nursing 6. Sex	Center 7. Age (In yrs. las	st birthday)	Prince If Under 1 Y		ederick Under 24 Hrs.	8. Date of Bir	Caly	g, Birth	place (State or Foreign		
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			Usual Residence of Decedent				1			oury 1	0, 1919				
	show	_	10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
	Ba-f s	cto		ce Georges	Fe Fe	orest									
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	s 234	by Funeral Director	2415 Wintergree		dent Ever in U.S.	13 1		747	ic Origin? (Spe	cify Yes or No	U.S		can Indian,		
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936	urs af		3 ₩ Widowed 4 Divorced	If Yes, Give Year or Da	e		1□ Yes 2√X	No Sp	ecify:		Speci	″y∷ Whi	te		
5-0036	in 72 hours after death with the Maryland I "naturel", or flems 23a or 28a-f show kolical Exerciter must be notified at	Completed	15. Decedent (Specify only highes.	s Education		16a. Dece	tent's Usual C	occupation	most of worki	na	16b. Kind of E				
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ž	should be fund Mental h marked of umatic eve	ဥ	James T. Green 6 19a. Informant's Name/Relationsh			19h Mailin	a Address (S	treet and N			er, City or Town	State Zi	n Code)		
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-	ges 1 an t of Heal if item 2 or other		20a. Method of Disposition	Ticpitew)	20b. Plac	ce of Dispo	sition (Name	of	- T	ate	20c. Location	- City or T	own, State		
ō	ages ant of it: If if		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		iaie		natory or other		; v:∐an	11 20	05 Chold	tonha	m MD		
Baltimore	permit. Pages Department of I Important: If ite any injury or of once.			Md. Veterans Cemetery Jan. 11, 2005 Cheltenham, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert P.A. 8125 Southern Maryland Blvd. Owings, MD 20736											
ã	permit. Departr Imports any inju	k 3	DOGIANO VE	noi / Cherc	χ										
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that ca	used the death.	Do not ent	er the mode o	f dying, su	ch as cardiac o	r respiratory a	rrest,		Approximate Interval Between		
	Physician	y n	Immediate Cause (Final	C	moline	1	ry he	140	ana.				Onset and Death 5 minutes		
	/Medical		disease or condition resulting in death)												
и	Examiner		Sequentially list conditions	b. AH	erosci	eno	be C	ardio	o Vaso	ular	diseas	e	More than		
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a conseque	nce of):									
	acute ind trans	Examlner	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseque										
50,	ate be executed obysician and the burial-transit		rosaking in dodiny East	Due to (c	or as a conseque	nce or):									
8760,	The law requires that the death certificate be executed as been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical		d											
9 ×	death certifica attending ph d for use as th	/Me	IF FEMALE:	23c. If ves. outo	ome of pregnanc	ev .					23d Da	ate of delive	arv		
Box	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐Live bi	nth 2 ☐ Fetal do ant at time of dea	eath 3	Ectopic pregr Other (specif					onth	Day Year		
P.O.	that the de ted by the a detached f	yslo	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkno			, , , , , , , , , , , , , , , , , , , ,	,,							
	res that igned b be deta		Part II. Other significant conditio	ns contributing to de	ath but not resulti	ing in the ur	nderlying caus	e given in i	Part I.	23e. Did t	obacco use con	tribute to t	he cause of death?		
rds	n sign	d be	Dementio	â						1 🗆	Yes 2□No	3 Prot	bably 4 Dunknown		
000	s been s	olete								24a. Was	an 24b.	Were auto	ppsy findings available		
Re	The law te has page 2 t	Completed								perfo	rmed?	death?	mpletion of cause of 2□ No		
of Vital Records,	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?					26.	Place of Death						
>	Physician: r this certifica ral director, p	P	1 Yes 2 No	Hospital: 1 □ Ir		NOutpatien			A 24 - 0 - 1		dence 6 □Oth		5/)		
0	ding Pl n. After tl funera		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date o (Monti	f Injury n, Day Year)	8b. Time of Injury		Injury at Work?		28d. Describe	how injury occur	red			
Sio	vttendii death. ctor: A y the fu	catl	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation	74 · A.1		М	1 🗌 Yes		104 Leasting /	Ctun nt am al Alcomi	has as Pos	al Route Number,		
Division	l or Atteno after death Director: I in by the	Certification;	4 Homicide determi	ned 28e. Place buildin	of Injury - At hom g, etc. (Specify)	e, tarm, str	et, factory, of	TICE	1	City or To	wn, State)	או טו העוצ	ai Aoute Number,		
-	ospital or A hours after uneref Dire ly filled in by		29a. Certifier 1 Certifying	Physicien: To the	hest of my knowle	edge death	occurred at t	he time da	ate and place a	and due to the	cause(s) and m	anner as s	tated.		
	24 hos 24 hos Fun etely	edical		xeminer: On the ba and mann	sis of examination										
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Me	29b. Signature and title of certifier				29c. Li	cense num	nber		29d. Date signs	d (Month,	Day, Year)		
	, , , P 0		Lyan	c. h	wane	4	\mathcal{D}	50	653		12-	31-	2004		
			30. Name and address of person v	vho completed cause	of death (Item 2	За) (Туре,	Print) G		1. C.	5/12	PNP				
_	10		5851- D	eak	Churc	chte		di	De	are	mo	. 20	1250		
	Sta		31. Date filed (Month, Day, Year)		egistras Signatur		-/	0 7	_						
	Registi	rar	JAN	0 4 2005	PEREUS.1	S.	STORAGE	- Pi							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 10:30P M Rudolph D. Smith 27 2004 December /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Genesis Elder Care @ Spa Creek If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. July 28 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** 1∰ M 2□ F 73 218-26-7650 1931 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show rat, or Items 23a or 28a-f show Examiner must be notified at 1 ∃Yes 2 No ⊉Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 USA 424 Chesapeake Ave Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No 3 Widowed 4 Divorced Year or Dates: "natural" er then "natura". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Naval Academy Cook 10th 17 is marked othe traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ernest Smith Catherine Brown ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 424 Chesapeake Ave Annapolis, Md. 21403 f Health I Jeannette Smith(Wife) othar 20b. Place of Disposition (Name of Besite of Programme Methodical) a 1 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of the Important: If its eny injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1 - 5 - 05Annapolis, Md. Park * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Wm. Reese & Sons Mortuary, P.A. 21. Signature of Funeral Service License Md . 21401
Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Divertication **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 1 Live birth 2 ☐ Fetal death Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No been si Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has 1 ☐ Yes 2 ☐ No certificate 1□ Yes 2500 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 3□ DOA this 28c, Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 5 Pending Injury 1- Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fr death. investigation 2 Accident the f 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 T Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

gistrar's Signatur

mic 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Jove

3 0 2004

31. Date filed (Month, Day, Year)

037036

2108 0. Donato Dr we Choster, MD 21619

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 4 42906 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year December 24,2004 **Physician** Dorothy Mae Springman 10:35PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Waldorf Health Care Waldorf Charles If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year)

July 23,1916 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1□ M 2□ F Days 578-28-8197 88 Director Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "neturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Charles Pomfret 1 ☐ Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4500 Bonds Place 20675 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Sullivan Lowe William Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Albert Bond/Son inlaw 4500 Bonds Place, Pomfret, MD 20675 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crem.12/31/04 Charlotte Hall, MD M00945 22 Name and Address of Facility AREHART - ECHOLS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 567 LA PLATA, MD 20646 BOX 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner ettending physiclan and I for use as the burial-transit the Hospital or Attending Physicien: The law requires that the death certificete be exacuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

EMEN

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2X No 1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 🔭 No 28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

27. Manner of Death 5 Pending investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 Homicide

Completed by

Be

2

Certification:

edical

this : After this e funeral

within 24 hours after death.

To the Funerel Director: A completely filled in by the fu

I Director: A

15/Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of cerlifier

s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addie

KAULMELION CT WALDORF MOZIGOZ

MP.3 State Registrar SHVIN

hysician /Medical =	1. Decedent's Na	me (First, Middle, I	.ast)	Manyland Sa-i pe me G84				2. Date of D	eath	Year	3. Time of	
	PAMEL.		STACHURA					DEC.			1632	РМ
Examiner	sa. Facility Name SHADY	GROVE AD	ive street and numb VENTIST H	ŐSPITAI	L		KVILLE		MON	ty of Death		
rector	5. Social Security	9070	Sex 7. 1 □ M 2 💢 F	Age (In yrs. I		If Under 1 Yes Months Day		Min. 8. Date of B (Month, D May 11	irth Pay, Year) 1963	9. Birthpla Country Maryl	ce (State o y) and	r Foreign
Mow M	Usual Residence 10a. State	10b. County			, Town or Lo					100	d. Inside Cit	•
be notified at Director	Md.	Montgon	nery	K	ockvi	10f. Zip Code	 0		10g. Citizen o	f What Countr		
0 9 0		lare Road	l.				20850			d State		
ar, or the		arried 2 <mark>X</mark> Married I 4 □ Divorced	12. Was Deced Armed Force 1	es? XNo		Was Decedent of If Yes, specify C		igin? (Specify Yes or N n, Puerto Rican, etc.) :	В	ace - America lack, White, et cify: White	c.	
or than "natural; it, the Medical Ex. Completed by	(St	15. Decedent's necify only highest	Education grade completed)		16a. Dece (Give	dent's Usual Oco kind of work do DO NOT use ret	cupation ne during mo	st of working	16b. Kind of	Business/Indu	istry	
d other than "naturevent, the Medical Be Completed	Elementary/Se	condary (0-12)	College (1-4	4or 5+)		act Lens			Optic	a1		
d oth		e (First, Middle, La omas Stac						er's Name <i>(First, Middl</i> vrtice Nell		ame)		
m 3		Name/Relationship	o (Type, Print) 7e11 (Daugl	nter)				er or Rural Route Num Rockville,			Code)	
If item 27 is marke or other treumatic TO	20a. Method of I	Disposition		20b. P	-	osition (Name of matory or other)		Dec. 22,	-	n - City or Tow	m, State	
ury or	1 🗆 Burial 1 4 🗀 Donatio	2 X Cremation 3 n 5 ☐ Other (Spe	□Removal from Stacify)	later i	ropol	itan Cre	em.	2004		dria, '	Va.	
Importent: If item 27 Is any Injury or other tre once.	21. Signature of	Funeral Service Li	Ory		1	2. Name and Ad O East I	dress of Facil	^{ity} DeVol Fun ark Dr. Gai	eral Ho thersbu	me rg, Md	. 208	77
igned by the attending physician and be detached for use as the burial-transit by Physician/Medical Examiner	disease or concresulting in deal Sequentially list if any, leading to cause. Enter Ucause Unisease that initiated everesulting in deal	conditions, o immediate of injury or injury ints	Due to (o	Drug 1 r as a conseq r as a conseq or as a conseq	uence of): uence of):							
gned by the attending ph be detached for use as th by Physician/Medi	IF FEMALE: 23b. Was deced in the past 1 \(\superset \text{Yes}\) 9 \(\superset \text{Unknown}\)	12 months? 2 □ No		th 2 ☐ Feta int at time of d	death 3	□Ectopic pregna □ Other (specify				Date of deliver Month [Year
d be deta	Part II. Other sig	nificant condition	s contributing to dea	ath but not res	uiting in the	underlying cause	given in Part		i tobacco use co] Yes 2 □ No			
cate has been si page 2 should Completed							-	per	as an copsy formed?	b. Were autop prior to com death? 1-8 Yes 2	sy findings pletion of c	available ause of
certificate rector, pag	examiner?	eferred to medical	Hospital:	unationt VV	EP/Outpatie	nat 3 T DOA	Othor	ce of Death (Check only lursing Home 5 Re		Other (Specify)	ı	
0 0	O 1 ZVes 2 No Investigation 1 Inpatient XX ER/Outpatient 3 DOA 4 Nursing H							28d. Describ	e how injury occ		ınk	
r: After this ce e funeral dire atlon; To	Z _ Accide	6 X Could no		of Injury - At h	ome, farm, s	treet, factory, off	ice	28f. Location City or T Rockvi	(Street and Number own, State) 2	mber or Rural 05 Adc.	Route Num	Road
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Funeral Director: After this content of the funeral directors of the funeral directors of the funeral direction of the funeral direction of the funeral direction of the funeral direction of the funeral direction of the funeral direction of the funeral direction of the function of the f	3 🖺 Suicide	1 Continuing	Scene	best of my kno	owledge, dea ation and/or i	ath occurred at th investigation, in r	ne time, date a my opinion, de	and place, and due to the ath occurred at the time	ie cause(s) and e, date and plac	manner as sta e, and due to	ted. the cause(s	s)
his T	3 ☐ Suicide 4 ☐ Homici 29a. Certifier (Check only one)	1 Continuing	Physician: To the xaminer: On the ba	best of my kno	owledge, dea	investigation, in r	ne time, date a my opinion, de cense number O.C.M.	eath occurred at the tim	e, date and plac	manner as state, and due to med (Month, E	the cause(s	s)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Month Year **Physician** 26 76 /Medical 4b. City, Town, or Location of Death Fecility Name (If not institution, give street and number) 4c. County of Death Examiner ChesTerTow River hesier Center HOSPITAL If Under 1 Year If Under 24 Hrs Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 15 M 2□F QCT, 17, 1936 68 Yrs. 217-28-2895 Director MID Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits or itams 23a or 28a-f show the Medical Examiner must be nutified at 1X Yes 2 No Director CENTREVILLE QUEEN ANNE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 BELVEDERE AVENUE 21617 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1962–1965 1 ☐ Yes 2 ▼No Specify Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 MASTER BARBER HAIRSTYLING 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth eny injury or other traumatic event 90s. 17. Father's Name (First, Middle, Last) FRANCES C. BIGGERS CHARLES EDWIN TURNER, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220 BELVEDERE AVE., CENTREVILLE, MD 21617 DELORES S. TURNER/ WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State CHESTERFIELD CEMETERY 12-31-2004 CENTREVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. X Illows 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter tre-disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobasco use contribute to the cause of death? Completed by Records, 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 🗌 Yes 2 No of Vital or Attending Physician: director. Certification: To Be Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of pertific 29c. License number 29d. Date signed (Month, Day, Year) D0057509 DEC. 28,2004 30. Name and address of person who completed of use of death (Item 23a) (Type, Print) 546 WASHINGTON AVENUE, CHESTERTOWN, MD 21620 JAMES LACEY, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28, 2004 **Physician** December Louise F. Toback 7:05A M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y FEB. 18, 9. Birthplace (Stete or Foreign **Funeral** Year) 1913 1□M 2**X**F 578-16-8583 91 Washington, DC Director Usual Residence of Decedent Manyland 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits 123s or 28s-f show 1 XYes 2 ☐ No Maryland Montgomery Germantown Direct the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 14920 Plainfield Lane 20874 United States of America death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ White 1 ☐ Yes 2 📈No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) **United States** al Hygiene. I other than vent, the Man Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant 12 Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental 27 is marked or traumatic ev Max Fishman Gertrude (Unascertainable) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages.
Department of Health are.
Important: If item 27 ier
any injury geother tran Stephen J. Press - Nephew 14920 Plainfield Lane, Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 12/30/04 Judean Memorial Garden Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Tottlenger Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland Donald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OCCEPTO /Medical consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, Physiclan/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown ģ ۵ signed by the pet det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 3 Probably 4 Donknown 1 □ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? ate 1 Tes 2 🗆 No 2 10 1 Tyes Hospital or Attending Physician: certific director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: ٩ 1 🗌 Yes 2 🗔 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Matural 5 Pending death. 1 Tes 2 No 2 Accident investigation within 24 hours after death To the Funeral Director; cumpletely filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. License number 0 Z 30. Ime and address of person who completed cause of death (Item 23a) (Type, Print) THEGOR Montrose 31. Date filed (Month, Day, Year) State 0 Registrar

			For State Registrar	State of Maryland		artment of H tificate of L		6	iene L	2910			
	Division		1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Year	3. Time of Death			
	Physici /Medic		ROSE C.	TODER		_		DECEMBER		10:50 P ^M			
	Examin		4a. Facility Name (If not institution, give st	·		4b. City, Town, or	Location of Dea	ith	4c. County of Dea	th			
			POTOMAC VALLEY NURS			ROCKVILLE If Under 1 Year	If Under 24 Hr	S O Date of Sint	MONTGOME				
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. last	Yrs.	Months Days	Hours Mir	. (Month, Day,	Year) Co	thplace (State or Foreign ountry)			
			Usual Residence of Decedent	92				MAY 4, 1	91Z NEW	YORK			
	yland Now		10a. State 10b. County	10c. City, T	own or Lo	cation				10d. Inside City Limits			
	a-fsi	ţċ	MARYLAND MONTGOMERY	ROCKV	ILLE					1 ☐ Yes 2X No			
	or 28	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Co	ountry?			
	ath w		1235 POTOMAC VALLEY			20850			U.S.A.				
	er de	Funeral	The Marian Gratag	2. Was Decedent Ever in U.S. Armed Forces?	13. \	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit				
36	hours after death with the Maryland turel', or Items 23e or 28a-1 show at Examinat must be mudited at	by F	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates:		I□Yes 2X No	Specify:		Specify: L	HITE			
Ş	2 hou	ed	15. Decedent's Educ	ation 1	6a. Deced	ient's Usual Occupa	ition		16b. Kind of Business				
212	nin 72 n "ni Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give lite. l	kind of work done a DO NOT use retired,	luring most of w)	orking		,			
21	giene grethe	Com	Elementary, boots and (6 12)		EACHE	R			EDUCATION				
p	al Hy d oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle, M	faiden Sumame)				
Maryland 21215-0036	Ment Ment arke	^o	AARON	COHEN			SARAH	•	FOGEL				
<u>a</u>	2 sh and is m		19a. Informant's Name/Relationship (Typ						City or Town, State, .	Zip Code)			
a)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or Items 23e or 28a-f show among young yo other treumatic event, the Medical Examinat must be notified at once.		ERIC TODER/SON 20a. Method of Disposition					IN JOHN,	MD 20818 20c. Location - City or	Town State			
Baltimore,	iges Hitoth		1 X Burial 2 ☐ Cremation 3 XRe	moval nom State		sition (Name of natory or other place			eoc. Location - City of	Town, State			
<u>=</u>	rit Pa	'4 Donation 5 Other (Specify) MT. HEBRON CEMETERY 01/02/2005 FLUSHING, 1 21. Signalurg-of Figure 1 Strice Licensee 22. Name and Address of Facility											
Ba	perm Depa Impo any i		21. Signal de Silver de Licolison	,	ED	WARD SAGE	I. FUNER	AL DIRECT	ION, INC.	0.50			
			23a. Part1. Enter the disease, or complic	ations that caused the death. [E, ROCKVI		Approximate Interval Between			
	Dhysisian		shock, or heart failure. List only one Immediate Cause (Final			D = 6 m				Interval Between Onset and Death			
	Physician / /Medical		disease or condition resulting in death)	Due to (or as a consequen		REST							
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	nd transi	Examiner	that initiated events C.										
ő,	e exe sian a urial-		resulting in death) Last	Due to (or as a consequen	ice of):								
8760	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d.										
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Вох	atten for u	Physician/M	in the past 12 months?	1 Live birth 2 Fetal de 4 Pregnant at time of death	ath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year			
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<u>. </u>	res that igned b be deta	by PI	Part II. Other significant conditions cont	ributing to death but not resultin	ng in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?			
rds	quires in sig	ed b	DEEP VENOUS THROMB	OSIS,				1 □ Ye	s 2. 1 № 3 □ Pr	robably 4 DUnknown			
000	aw requir s been s 2 should	olet	HYPERTENSION, DEMEN	TIA, ANEMIA				24a. Was ar		utopsy findings available			
Ä	The law ate has page 2 s	Completed						autops perform 1 Yes 2	ned? death?	completion of cause of 2 □ No			
Vital Records,		Be C	25. Was case referred to medical				26. Place of De	eath (Check only one					
<u>_</u>	S D	10 8	examiner? 1 ☐ Yes 2 X No	spital: 1 Inpatient 2 ER	/Outpatien	t 3□ DOA Cthe	r: 4 🛚 Nursing	Home 5 ☐ Reside	nce 6 Other (Spe	cify)			
0	ding Phy h. After thi funeral	on:	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28	b. Time of Injury	28c. Injury Work	at ?	28d. Describe ho	w injury occurred				
Sio	Attending or death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				res 2 ☐ No						
Division of	or Attendate death Director:	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (Str City or Town	eet and Number or Ri , State)	ural Route Number,			
	ospitel or A hours after unerel Directly filled in by		29a. Certifier 1X Certifying Physi	cian: To the best of my knowle	dan dant			and due to the on		a de ta d			
	T 24 T B	edical	(Check only one)	er: On the basis of examination and manner stated.	and/or inv	estigation, in my op	pinion, death occ	curred at the time, da	ite and place, and due	o to the cause(s)			
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0 ;		29c. License	number	29	d. Date signed (Mont	h, Day, Year)			
	,		11 20.	la		DOO	60036	D.	בר באטבט פר	2004			
	6		30. Name and address of person who con	npleted cause of death (Item 23	Ва) (Туре,		00030	D.	ECEMBER 30	, 2004			
			MAHMOUD DOSKI, M.D.	, 1299 LAMBERT	ON D	RIVE, SIL	VER SPR	ING, MARY	LAND 20902				
	Sta		31. Date filed (Month, Pay, Year) 3 20	32. Figistrar's Signature	K D	parte							
	Registr	ar	טחוז ט ט בט	A CONTRACTOR OF									

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	Physici	an	1. Decedent's Name (First, Middle, Las	,						!	2. Date of De Month				3. Time of D	eath
	/Media	al	Virginia May 4a. Facility Name (If not institution, give		-)		41- 01		Local		Decembe	er 3	0 200	4 9	:10 P	М
1	Examir	ier	Frederick Me		•	al.		y, Town, or reder:		r Death			c.County of D rederi			
	Funeral		5. Social Security Number 6. Se	7. A		last birthday)		ler 1 Year	If Under 2	24 Hrs. Min.	8. Date of Bir				e (State or I	Foreign
	Director		214-/6-3541	☐ M 2 12 F	75	Yrs.	Monu	s Days	Hours	MID.	8. Date of Bir (Month, Da May 22,	19	29 Vi	rgini	ia	
	ow at		Usual Residence of Decedent 10a. State 10b. County	-	10c. Ci	ty, Town or Lo	cation		<u> </u>					10d.	Inside City	Limits
	e-fsh	tor	Maryland Frede	rick	Wa1	kersvi	l1e								1 Yes 2	No
	or 28	Direc	10e. Street and Number					ip Code				10g. Ci	tizen of What	Country?	?	
	s 23a	ral	8525 Water Stree					21793					.S.A.			
' 0	ther de	Funeral Director	11. Marital Status 1 Newer Married 2 Married	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑	?/	J.S. 13.	Was Dec	edent of Hi ecify Cubai	spanic Orig n, Mexican,	gin? (Spe , Puerto f	cify Yes or No Rican, etc.)	-	14. Race - A Black, W	merican I /hite, etc.	Indian,	
036	ral', o	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2 No	Specify:				Specify:	wh	nite	
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28e-1 show the Modical Examither must be multined at	Completed	15. Decedent's Ed (Specify only highest grad			16a. Deced	dent's Us kind of v	ual Occupa vork done d use retired)	tion uring most	of workir	ng	16b. K	(ind of Busine	ss/Indust	try	
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<u>d</u>	t Hygi other	Be Co	17. Father's Name (First, Middle, Last)			Industr	ссер		18. Mother	r's Name	(First, Middle,					
/lar	wild be Menta arkad artic ev	To B	William Sours						Mam	ie Be	elle Fo	x				
Baltimore, Maryland	perritt. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Importent: If item 27 Is marked other than "natural", or items 23a or 28e-1 show any injury or other treumatic event, the Medical Examinat matche notified at once.		19a. Informant's Name/Relationship (7) Catherine Hackley		er	19b. Mailin 3029 I	g Addre	ss <i>(Street</i> a er Roa	nd Number ad, G	r or Rural lynd (Route Numberon, Mar	ylaı	or Town, State	e, Zip Cod 1071	de)	
ore,	jes 1 a of He if item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Removal from State		Place of Dispo	sition (N	ame of other place			ate		ocation - City			
ţ	t. Pag trment rtent: ijury d	*4 Donation 5 Other (Specify) Resthaven Memorial Jan 5, 2005 Freder: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral										cy1and	1			
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9	tificate ng phy as the	ledic		16 -/			- 1.0									
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth			Ectopic	pregnancy					23d. Date of	,		
P.O. E	the all	ysici	1 Yes 2 No	4☐ Pregnant a 9☐ Unknown	t time of d	leath 5	Other (Month	Day	Yea	ı,r
	res that the de	by Ph	Part II. Dthar significant conditions co	ntributing to death I	out not res	ulting in the un	derlying	cause give	n in Part I.		23e. Did to	obacco (use contribute	to the ca	use of deat	th?
Records,	w requires been sign should be	ed b		····							1 🗆 Y	es 2	X No 3□	Probably	4 Unk	nown
eco	e law re has bed je 2 sho	Completed									24a. Was autop	an	24b. Were	autopsy f	indings ava	ıılable
	The l	Con									perfor		death	?	tion of caus	e oi
Vital	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:	8	,		Othor			Check only or				-705	
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Division of	of or Atte after dea Directo	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At ho tc. (Specif	ome, farm, stre	et, facto	ry, office		28	8f. Location (5 City or Tow	itreet an n, State	d Number or	r Rural Route Number,		;
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifice completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best nar: On the basis of and manner st	it examina	wledge, death tion and/or inv	occurre	at the time	, date and nion, death	place, ar occurred	nd due to the o	ause(s)	and manner I place, and d	as stated.	cause(s)	
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			1 Stee	MIS			D	426	411	Var	yland	15	2-31	-2	004	
	6		30. Name and address of person who co	mpleted cause of o	death (Item	1 23а) (Туре, Р	Print)	_ ~	_	1	yland ck.)	,		
	-64		Stephen Lee M. 31. Date filed (Month) Back Year) A	D 610	S Old	ture	COU	r1 , 1	-rea	eri	ck.	Ma	rylan	dó	2170	3
	Sta Registra		JAN U 4 21	105	Stad .	A A	25456	3								

Lacole 04-8390^{Taylor} AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	_		Registrar 1. Decedent's Name (First, Middle, Last))	Ce	runcate or i	Jealii	2. Date of De	Reg. No.	3 Time of Death
	Physici /Medio		Lacole Taylo	•					per 27, 2004	2:30 P M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or		h	4c. County of Death	
			5951 Hilmar Drive 5. Social Security Number 6. Se	7 400 //0 11	n land hirthday	Forestvi	LLE If Under 24 Hrs	0.000-400	Prince Geo	
Н	Funeral Director			м № г 32	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Bin (Month, Da July 18	y, Year) 9. Birth	place (State or Foreign ingtonDC
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	1 the ?	Director	10e. Street and Number	was	JIIII COI	10f. Zîp Code			10g. Citizen of What Cou	ntry?
	th with 23a o	al D	5218 Fitch St SE	# 9		20019			United State	28
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent of H	ispanic Origin? (S In, Mexican, Puer	pecify Yes or No to Rican, etc.)	- 14. Race - Ameri Black, White,	
36	within 72 hours after death with the Maryland ane than "natural", or liems 23a or 28e-f ahow he Medical Examitian", ust be invitibled at	by Fi	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1☐Yes 2ሺ No	Specify:		Specify: Blad	2k
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Baltimore,	0 0		1X Burial 2 □ Cremation 3 □ I	Removal from State	cemetery, crei	matory or other place Memorial			Landover MD	own, State
altir	T E E E		21. Signature of Funeral Service Licens		emetery22	2. Name and Addres	s of Facility A1		S. Pope Fune	ral Home
m	permi Depa Impo any ir		Jaconski	Naws	- 2	2617 Penn	Ave SE	Washingt	on DC 20020	
6			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the de ne cause on each line.	ath. Do not ent	er the mode of dyin	g, such as cardia	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	huperter		theroscle	rotico	beliouse	wer diseas	e
	Examiner			(or as a cons	equence of):					
	p #	iner	Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or se a cone	equence of):					
	ecute and I-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a cons	equence of):					
8760,	cate be executed physician and the burial-transit	dical E		d	04001100 01).					
9	tificate ng phy as the	ledic		U						
Вох	eath certifi attending	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy			23d. Date of delive	ery Day Year
0.	The law requires that the death certifi sie has been signed by the attending page 2 should be detached for use as	Physiclan/Me	1 Yes 2 No	4 ☐ Pregnant at time of 9 ☐ Unknown	fdeath 5□	Other (specify)			North	Day Teal
٥	s that t	by Ph	Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute to the	ne cause of death?
Records,	w requires been sign should be	ed b	_obesity					1 🗆 1	res 2 □ No 3 □ Prob	ably 4 Unknown
ecc	e law re has be	Completed	<i>U</i>					24a. Was		psy findings available mpletion of cause of
<u>=</u>		Соп						perfo	rmed? death?	2 No
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 X Yes 2 \sum No	Hospital:		t all DOA Othe		ath (Check only o		
of		\vdash	27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time of	28c. Injury	at Nursing P		dence 6 X Other (Specification of the second of the secon	at scene
ion	Attending Firdeath. ector: After by the funer	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1 🗀 🗅	(? Yes 2 □ No			
Division		ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	eet, factory, office		28f. Location (S City or Tow	Street and Number or Rura vn, State)	l Route Number,
Ω	pital cours at eral D	0	29a. Certifier 1 ☐ Certifying Phy	sician: To the best of my k	nowledge death	a cooursed at the time	an data and alass	and due to the	20122(2) 224 - 2222 - 22	lated.
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	edical	(Check only one)	ner: On the basis of examinand manner stated.	nation and/or in	vestigation, in my op	pinion, death occu	rred at the time,	date and place, and due to	the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier	00-		29c. License	number		29d. Date signed (Month,	Day, Year)
<u>^</u>			fate Un	- Kalle	10	O.C.M	И.Е.]	December 28,	2004
K			30 Name and address of person who co	ompleted cause of death (It	em 23a) (Type,		Street	Raltim	ore, Marylan	d 21201
	Sta	nte	31. Date filed (Month, Day, Year)	2. Registrar's Sig	natura	TIL LEIII	DLIEEL,	рат стії(ore, maryran	u 212Ul
	Registr		IAN 0 3 2005	Kontra . h	1 Some	P. I				

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Rockville

4b. City, Town, or Location of Death

Reg. No.

December 27, 2004

4c. County of Death

Montgomery

3. Time of Death

12:25 PM

9. Birthplace (State or Foreign

20012

month

Day

3 Probably 4 Unknown

Year

Month

Approximate Interval Between Onset and Death

10d. Inside City Limits

1X Yes 2 No

Haiti

Black, White, etc.

2. Date of Death

State

Registrar

Chita Rajagopal

31. Date filed (Month, Day, Year)

DEC

M.D.

30 2004

1 - State Registre

Physician

/Medical

Examiner

. Decedent's Name (First, Middle, Last)

Casey House

Merius Merite Thelusma

4a. Facility Name (If not institution, give street and number)

			For State Registrar	State	of Marylar		artment of <i>tificate o</i>		nd Mer		jiene 0	04	42914	
			Decedent's Name (First, Middle,	Last)					2.	Date of Dea Month	th Day	Year	3. Time of Death	
	Physicia		Robert	Monroe	Tregor	ning			D		er 30,		11:30P M	
	/Medic Examin		4a. Facility Name (If not institution,	give street and no	umber)		4b. City, Town	or Location of	f Death		4c. Coun	ty of Death		
		•	23715 Ridge Ro	oad			German	town			Mont	gomer	У	
Ī	Funeral			6. Sex	7. Age (In yrs.		If Under 1 Year Months Day	r If Under 2	Min. 8.	Date of Birth (Month, Day	Year)	9. Birthp	lace (State or Foreign	
	Director		215-36-5028	1 X M 2□ F	72	Yrs.	Working Suy			y 23,		Mary		
	p .		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ity, Town or Lo	cation					1	0d. Inside City Limits	
	sho	5				• ·							1 ☐ Yes 2 📉 No	
	he M	Director	Maryland Montgo	omery	G€	ermanto	Wn 10f. Zip Code				log. Citizen of	What Cour	itry?	
	with B or	늅					208					S.A.	,.	
	eath	Funerai	23715 Ridge Roa		cedent Ever in U	J.S. 13.1			in? (Specify	v Yes or No-		Ce - Amend	an Indian,	
_	Itan	'n.	1 Never Married 2 Marrie	Armed F	orces? 2 X No	10.	Was Decedent of f Yes, specify Cu	iban, Mexican,	Puerto Ric	an, etc.)	ВІ	ack, White,		
0000	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or	ive		1⊡Yes 21X7N	o Specify:			Spec	ity: Whi	te	
รุ	be filed within 72 hours after death with the Maryland Hygiene. ad other than "natural", or Itama 23a or 28e-f show other than "natural", or Itama 23a or 28e-f show event, Ita Madical Examinar must be notified at	ted	15. Decedent	s Education		16a. Deced	ient's Usual Occ	upation	-4		16b. Kind of	Business/In	dustry	
2	hin 7.	Completed	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work dor DO NOT use reti	red)	or working					
7	d with	Ö	12			F	armer				Farmi	.ng		
aua	e file al Hy l othe vant,	Be (17. Father's Name (First, Middle, L	.ast)				18. Mother	r's Name (F	irst, Middle,	Maiden Suma	ime)		
<u>a</u>		70	John M. Trego	oning				Mab	el W	atkins	3			
al	s 1 and 2 should be t f Health and Mental I ltem 27 is marked o other traumatic eva		19a. Informant's Name/Relationsh				ng Address (Stre				-			
Σ.	and all n 27		Patricia S. Tre	goning -			5 Ridge	Road,					20876	
9	of Her		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from		Place of Dispo cemetery, crer	sition (Name of natory or other p	lace)	Date	•	20c. Location	- City or To	own, State	
Ĕ	Pag nent ant: f ury o		'4 ☐ Donation 5 ☐ Other (Sp			. 01iv	et Ceme	tery J	an. 6	, 2005	Fred	erick	, Maryland	
Бант	permit. Pages 1 an Department of Heal Important: if Item 2 any Injury or other once.		21. Signature of Funeral Service L	Densee) /.	11.) 22	Name and Add	ress of Facility	rth P	.A F	uneral	Home		
n	205 2 3		Hover L	. Nul	Man	2	6401 Ric	lge Roa	d, D	amascu	ıs, Mar	yland	20872	
			20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death											
	Physician		Immediate Cause (Final disease or condition		meta	(tate	An	gio s	Clare.	ema		1	Onset and Death	
	/Medical		resulting in death)	Due to	(or as a consec	quence of):	1 11 %	9.00		-1.1.0		,	1 1 WINDT	
	Examiner		Sequentially list conditions,	b										
	ס #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a consec	quence of):								
	ecute and trans	am	that initiated events resulting in death) Last	c	c									
Š,	be executed ician and burial-transil	Ē	Tosulang in dodain, Last	Due to	o (or as a consec	querice or):								
g/p	ate b	dicai		d										
ک ک	the death carificate be executed y the attending physician and ached for use as the buriat-transit	/Me	IF FEMALE:	23c If yes o	utcome of pregn	iancy					224 0			
gog	ath c	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Fet	al death 3	Ectopic pregnar Other (specify)				1	ate of delive Ionth	Day Year	
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unk	gnant at time of a nown	death 5L	3 Other (specify)							
J.	w requires that the de been signed by the should be detached	by Physician/Me	Part II. Other significant conditio	ns contributing to	death but not re	sulting in the u	nderlying cause	given in Part I.		23e. Did to	bacco use co	ntribute to t	ne cause of death?	
ecords,	The law requires that ite has been signed b age 2 should be deta									1 □ Y	es 2 00	3 ☐ Prot	ably 4 Unknown	
Ö	requ	etec								24a. Was a	246	More auto	psy findings available	
ě	has has	Completed								autop perfor	sy	prior to co death?	mpletion of cause of	
<u>=</u>										1 Yes	21 No	1 🗆 Yes	2□ No	
Zig	aiclan: The law certificate has b irector, page 2 si	Be	25. Was case referred to medical examiner?	Hospital:		7.50/0)ther		Check only of		h (0)		
Ö	Phys rahdi	10	1 Yes 2 No 27. Manner of Death		Inpatient 2	28b. Time o	IL 3L DOA	4 🗀 Nui			ence 6 0 ow injury occu		y)	
Ö	ding h. Afte fune	tion	1 XNatural 5 ☐ Pending 2 ☐ Accident investig	g (Mo	nth, Day Year)	Injury	V	/ork? □Yes 2□1	No					
DIVISION	Atten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Plac	ce of Injury - At h	nome, farm, str	reet, factory, office	:ө	28f			nber or Rura	i Route Number,	
\leq	after Dira Jin b	Certification;	4 Homicide	buil	ding, etc. (Speci	ify)				City or Tow	n, State)			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director.		29a. Certifier 1 Certifyin	g Physicien: To th	he best of my kn	owledge, deat	h occurred at the	time, date and	d place, and	due to the d	ause(s) and r	nanner as s	tated.	
	• Ho 24 h a Fu letely	Medical	(Check only 2 Medical I	Exeminer: On the	basis of examin inner stated.	ation and/or in	vestigation, in m	y opinion, deat	th occurred	at the time, o	date and place	, and due to	the cause(s)	
	To th within To th	Me	29b. Signature and title of certifier				29c. Lice	nse number		1	29d. Date sign	ed (Month,	Day, Year)	
	0		Dar K	els	mo	\supset	D	63	49		1~ 7	_ /	31	
			30. Name and address of person	no completed ca	use of death (Ite	em 23a) (Type,	Print)	الحور ف			1			
			John E. Kell	y Mb	2401	Rev	Learch	31	u d	Roc	Kull	e M	D 20550	
	Sta	te	31. Date filed (Months Pax Year)	2005 32.	Registrar's Sign	nature	Carroth 5						-	
	Registr	ar	-	-	A STATE OF THE STA	And the state of t	A COLOR OF THE PARTY OF THE PAR							

			_ State	Maryland / D	epari Certi	tment of He ficate of D	ealth and M Death		iene 2	004	42915
7			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Deat	th		3. Time of Death
	nysicia		Anthony 3	J. Valerio				Decembe	r 30	$2\overset{\scriptscriptstyle{Yeer}}{004}$	1:00 PM
	Medic xamin		4e. Fecility Name (If not institution, give street and num	nber)	4	lb. City, Town, or L				ty of Death	
			7532 Merrymaker Way			Elkridge			How	T	
	neral ector		5. Social Security Number 218 40 9030 6. Sex ★ M 2□ F	7. Age (In yrs. last birth		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 3,	1943	9. Birthpi Coun Mary	lace (State or Foreign try) Land
pu			Usual Residence of Decedent 10a, State 10b, County	10c. City, Town	or Loca	tion				11	0d. Inside City Limits
lanyla	a Da	5	_	Elkrid							1 ☐ Yes 2X No
the N	illo	Director	MD Howard 10e. Street and Number	EIKLIG	ige	10f. Zip Code	·	1	Og. Citizen of	What Coun	itry?
with	4	0	7532 Merrymaker Way			21075	5		Unite	d Stat	tes
death	in the	Funeral		ident Ever in U.S.	13. Wa	s Decedent of His	panic Origin? (Sp	ecify Yes or No-		ce - Americ	
should be filed within 72 hours after death with the Maryland of Mental Hygiene.	event, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☑ Married ☐ Yes	2 No		'es, specify Cuban;] Yes X □ No	Specify:	nican, ecc.)	Spec	ack, White, o	nite
hour i	E		15. Decedent's Education		Deceder	nt's Usual Occupat	tion		16b. Kind of		
in 72	Aedic	plet	(Specify only highest grade completed)	((Give kir	nd of work done du NOT use retired)	iring most of work	ing			,
2 should be filed withing and Mental Hygiene.	The Part	Completed	Elementary/Secondary (0-12) College (1	Sa Sa	les	man			Autom	obile	
al Hy	vent	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Surna	me)	
y outd b	atic	인	Frank Mancini				Incoronat				
2 sh	othar traumatic		19a. Informant's Name/Relationship (Type, Print)			Address (Street an					Code)
1 and 2 Health	hart		Marian S. Valerio/Wife 20a. Method of Disposition	75 20b. Place of I		Merrymake			MD 21 20c. Location		wn State
Pages nent of h	0		1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from	State	, crema	tory or other place,		2005		•	
it. Pa	any injury or o		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Mt. V		Cemetery					lle, MD
permit. Depart	any ir		> Stem Collis - Vit	101044 12							MD 21043
			23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	ach line	ot enter	the mode of dying,	, such as cardiac				Approximate Interval Between
Phys	ician		Immediate Cause (Final disease or condition	ur	6	- Can	CON				Onset and Death
/Me	dical		resulting in death)	or as a consequence of						- '	0
Exan	niner _.		Sequentially list conditions, b.								
P	sit	lnei	if any, leading to immediate Due to cause. Enter Underlying Cause (Disease or injury	or as a consequence of	f):						
xecut	II-tran	Examiner	that initiated events c	or as a consequence of	f):						
o ed e	the burial-transit	dlcal E	L _a								
ificate	as the	edlo	0.								
h cert	esn.	M/W	23b. was decedent pregnant	come of pregnancy inth 2 Fetal death	3 □ E	ctopic pregnancy			1	ate of delive	,
Attanding Physician: The law requires that the death certificate be executed at death.	should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregn	ant at time of death		Other (specify)			14	lonth	Day Year
Tat th	letach	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to de	eath but not resulting in	the und	orbing cause giver	n in Part I	23e Did tol	hacco use co	ntribute to th	e cause of death?
ires if	e d b	l by	Momeninglal	Carcinon		PS:	IIIII Fait I.	1 X Y		3 Prob	
law requires I	shout	etec	A and A	nstaces				24a. Was a	24h	Ware auto	psy findings available
9 a	962	Completed	Born Chall					autops	med?	prior to cor death?	mpletion of cause of
cian: T	or. pa	e Co	25. Was case referred to medical				26. Place of Deat		2 No	1 🗆 Yes	2 ∐ No
/sicia	direct	0 8	examiner?	inpatient 2 ER/Out	patient	3□ DOA Other	r	me 5 ☑ Reside		ther (Specifi	<i>(</i>)
2 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	neral o	n: T	27. Manner of Death 28a. Date	of Injury 28b. Ti	ime of	28c. Injury	at	28d. Describe ho			
ath.	he fur	atlo	2 Accident investigation		17		es 2 No		<u>-</u>		
or Attanding after death.	to the Funatal Difector; Affer this certificate has completely filled in by the funeral director, page 2	Certification:		of Injury - At home, faring, etc. <i>(Specify)</i>	m, stree	t, factory, office		28f. Location (Si City or Town	treet and Nun n, State)	nber or Rura	l Route Number,
pital o	led i		29a, Certifier 1⊠ Certifying Physician: To the	hast of my be sydedge	donah	and at the time	- data and plans	and due to the o	(a) and a		atad
To the Hospital or vithin 24 hours after	etely i	edical	(Check only 2 Medical Examiner: On the b								
To the	ldmos	Me	29b. Signature and title of certifier	0	-	29c. License	number	2	9d. Date sign	ed (Month,	Day, Year)
			1 / N XO 1) - W	M	D	1)	0054	911.	Januar	y 4, 2	2005
2			30 Name and address of person who completed caus	se of death (tem 23a)	Type, Pr	int) 1 1	-11	KIN- A	ME A	a 11: 1.	00 -1 0 21211
102			31. Date filed (Mohth, Day, Year) 32.	Oh / A4	-01	M. D	EIVER	ere 11	10,0	WITIM	DIEMDAN
F	Sta Registr		JAN 0 4 2005	Educ &	Long	26.					

			For State Registrar		State of N	1aryland				ealth a Death			Reg. No	21111	+ 42	916
	Physicia /Medic Examin	an cal	1. Decedent's Name (Firs Tibor Andr 4a. Facility Name (If not in	rew Vinc		r)		4b. City,	Town, or	Location of		2. Date of De Month	Day 25,	Yea 2004 County of D	12:2	of Death
	Funeral Director		4978 Sentin 5. Social Security Number 111.20.4220	6. Sex		ige (In yrs. la 94	-	Beth If Under	esda 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bin (Month, Da Mar • 13	th y, Year) ,191	ontgon 9.1 0 Hu	ery Birthplace (State Country) Ingary	or Foreign
e Maryland	Ba-f show	ctor	MD Me	County ontgomer	У		, Town or Lo nesda									City Limits es 2 ☐ No
5-0036 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: or items 23a or 28a-1 show Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.	Completed by Funeral Director	10e. Street and Number 4978 Sentin 11. Marital Status 1 □ Never Married 2	12	#206 Was Deceder Armed Force 1 Yes 2	?		f Yes, spe	316 dent of Hi cify Cuba	n, Mexican,	gin? (Spec , Puerto F	cify Yes or No lican, etc.)	USA	14. Race - A Black, W	merican Indian, hite, etc.	
21215-0036 od within 72 hours aft	nen "natural", o a Medical Exan	npieted by	3 ☐ Widowed 4 ☐ □	Divorced Decedent's Educative highest grade	tion completed) College (1-40	- WW-I	16a. Deced (Give life.	kind of wo	al Occupa rk done d se retired	luring most	of workin	g		Specify:		
Maryland 21	Mental Hygier harked other th	To Be Cor	17. Father's Name (First, Wilmosh Vi	Middle, Last)	5+			nysic		Lur	a Ku	(First, Middle,	, Maiden	Sumame)	- Zin Code)	
nore, Mar ages 1 and 2 sh	nt of Health and t: If item 27 Is m r or other traum		19a. Informant's Name/F Clinton A. 20a. Method of Dispositio 12 Burial 2 Cre	Vince /	Son	e Par	5015 lace of Dispo	Over	look	Rd.	N.W.	WDC ate	200. Lo	L6 cation - City	or Town, State	
Baltimore,	Departme important any injury once.		21. Signature of Funeral	Service Licensee	Sugg		- 5	130	Visco	ss of Facility	Jose Ave.	ph Gaw	ler'	s Sons	Inc.	
1	nysician Medical xaminer		23a. Part1. Enter the dis shock, or heart fail. Immediate Cause (Final disease or condition resulting in death)	ure. List only one	Cardio	line. Sulmon as a consequ	ary Ar	rest		g, such as	cardiac oi	respiratory a	rrest,		5 minu 20 yea	d Death 1tes
8/60,	hysician and the burial-transit	cai Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.		as a consequas a consequ										
Geath certific	e attending p od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 □ Yes 2 □ No 9 □ Unknown	gnant	c. If yes, outcom 1□Live birth 4□Pregnant 9□Unknown	2 ☐ Fetal at time of de	death 3	□Ectopic p □ Other (s						23d. Date of Month	delivery Day	Year
ecords, P.O.	been sign should be	Completed by Ph	Part II. Other significant Genitourina		ributing to death	but not resu	ulting in the u	nderlying (cause give	en in Part I.		1 □ 1	Yes 2	□ No 3 □	Probably 4 5	☑Unknown gs available
T e	ate h page	Be Comp	25. Was case referred to examiner?	o medical	-					26. Place	of Death	auto perfo 1 Yes	rmed? 2 ☑ No	death	to completion of ? 'es 2 \bigsi No	cause of
o à	h. After this funeral di	၉	1 ☐ Yes 2 ☑ No 27. Manner of Death	☐ Pending investigation	spital: 1 ☐ Inpa 28a. Date of li (Month, I		ER/Outpatier 28b. Time o Injury		28c. Injun Wor		2	ne 5 ½ Resi 8d. Describe			pecify)	
5	ours after deat eral Director: filled in by the	il Certification:	4 Homicide	Could not be determined	<u> </u>	etc. (Specif)	v) 			no data an		City or To	wn, State	·) 	Rural Route Nu	ımber,
To the Hospital	within 2 To the	Medical	29a. Certifier (Check only one) 29b. Signature and title of	Certifying Physi Medical Examin of certifier	er: On the basis and manner	of examina	wieuge, deat tion and/or in	vestigation 29	c. Licens	pinion, deat	u piace, a	ed at the time,	date and	te signed (M	onth, Day, Year,	
	80		30. Name and address of Lawrence I	E. Klein	, M.D.			Print)			W. #	349, WI	-	20016	,, 2004	
	Sta Regist	ate rar	31. Date filed (Month, Da	30 200	32. Degi	strar's Signa	ture 19	do	aks	1						

			For		nd / Dep	artment of Health a		giene	1.2017
			- State Registrar		Ce	rtificate of Death		Reg. No UUL	46311
	Dhuaiais		1. Decedent's Name (First, Middle, Last)				2. Date of De. Month	ath Day Year	3. Time of Death
	Physicia /Medic Examin	al -	Benjamin Weinmann 4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or Location of		er 26, 2004 4c. County of Dea	9:00 A ^M
	Examin		10528 Farnham Dr			Bethesda		Montgome	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yr M 2□F 87	s. last birthday Yrs.	If Under 1 Year If Under 2 Months Days Hours	Min. (Month, Da		thplace (State or Foreign puntry) ew York
	ס		Usual Residence of Decedent 10a. State 10b. County		City, Town or L	ocation			10d. Inside City Limits
	Maryi	to	Maryland Montgom	erv	Bethes	da			1 ☐ Yes 2 No
	n the	irec	10e. Street and Number			10f. Zip Code		10g. Citizen of What C	ountry?
	th wit	aD	10528 Farnham Dr			20814		USA	
	r dea	ner	TI. Walter States	Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	14. Race - Am Black, Whi	
5	irs afte	by Funeral Director	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ No If Yes, Give Year or Dates:	WWII	1 ☐ Yes 2 ☐ No Specify:		Specify:	White
5	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23s or 28e-f show any orient: if Item 27 is marked other than "natural; or Items 20s or 28e-f show any july or other traumatic avent, the Madical Exam at must be rividified anone.	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	edent's Usual Occupation e kind of work done during most DO NOT use retired)	of working	16b. Kind of Business	
V	within ene. than '	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)		ifiéd Public A		Accoun	ting
2	filed Hygie other	ပိ	17. Father's Name (First, Middle, Last)	4	Cert		's Name (First, Middle,		cing
O.	lid be lenta! ked c	To Be	Samuel Weinmann			Rose	e Rotter		
ar y	shou and M e mer		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mail	ling Address (Street and Number	or Rural Route Numb	er, City or Town, State,	Zip Code)
≥	and 2 saith a n 27 i		Lillian Weinmann/	Wife		8 Farnham Dr, 1			
2	of He		20a. Method of Disposition 1 □ 1 □ 2 □ Cremation 3 □ Re	emoval from State		osition (Name of ematory or other place)	Date	20c. Location - City or	
Saltimore	tment tant:		' 4 □Donation 5 □ Other (Specify)			Memorial Garden 22. Name and Address of Facility	and the same of th		ey, MD
ם	permil Depar Important Ir any Ir		21. Signature of Funeral Service License	, , , ,		1800 New Hamps			
			23a. Part1. Enter the disease, or complice shock, or heart failure. Ust only one	cations that caused the de					Approximate Interval Between
	Physician		Immediate Cause (Final			entricular Fail			Onset and Death Immediate
	/Medical		disease or condition resulting in death)	Due to (or as a cons					
	Examiner		Sequentially list conditions.			clerotic Cardi	ovascular I)isease	16 yrs
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a cons	equence of):				
	be executed ician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a cons	equence of):				
٥		calE	L _a						
ĝ	w requires that the death certificate been signed by the attending phys should be detached for use as the	ledi							
X Q Q	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F	etal death 3	□Ectopic pregnancy		23d. Date of de Month	olivery Day Year
j I	the attenthed for u	Physiclan/Medl	1 Yes 2 No	4□Pregnant at time o 9□ Unknown	f death 5	Other (specify)			,
Ţ	that the ed by detac	, Ph	Part II. Other significant conditions con	tributing to death but not	resulting in the	underlying cause given in Part I.	23e. Did 1	obacco use contribute	to the cause of death?
ecords,	requires that the veen signed by th hould be detache	d by	Adult onset diabe	tes mellitu	s Hi	story of Arrhy	thmia ₁□	Yes 2 □ No 3 □ P	robably 4 🛣 Unknown
000	s beer	olete	History of stroke	<u>.</u>			24a. Was	an 24b. Were a	utopsy findings available completion of cause of
Ľ	sician: The law s certificate has b lirector, page 2 s	Completed	Chronic renal ins		·		perfo	ormed? death?	s 2 No
VItal H		Be C	25. Was case referred to medical				of Death (Check only		
01	hysic this ce	2	1 ☐ Yes 2 💢 No	ospital: 1 Inpatient 2				dence 6 Other (Sp.	ecify)
	ding Phys h. After this c	tlon:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time Injury			now injury occurred	
Division	Attendi death. ctor: A	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A			28f. Location (Street and Number or F wn, State)	Rural Rout Number,
2	al or / s after il Dire	Certification:	4 Homicide	building, etc. (Spe	ecity)		City or 10	WII, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (29a. Certifier 1 Certifying Phys (Check only one) 29a. Certifier 1 Certifying Phys 2 Medical Exemin	ician: To the best of my ler: On the basis of exame and manner stated.	knowledge, dea ination and/or	ath occurred at the time, date and investigation, in my opinion, deat	d place, and due to the th occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	o the ithin ?	Mec	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mor	th, Day, Year)
	5		Lisa B. lapp	untern 1.0	-	DC17452		January 2	7, 2004
			30. Name and address of person who co	mpleted cause of death (tem 23a) (Type	e, Print)			
_			Lisa B. Sapperst			necticut Ave, N	W, #103, W	ashington,	DC 20015
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Pogistrar's Si	gnature	porte			
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7/10A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT N. WALTER LT MC USN State 31. Date filed (Month, Day, Year) PLANTIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600		pitaf ours a aral I	O	202 Cartifier W Cartifying P	hyeicien: To the her	et of my kny	owledge dea	th occurred	at the tim	o data and	d place of	and due to the	22122(2) 2	od mannar as r	
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Laverne White SS# 315,58-5608
Baltimore, Marvland 21215-0036

		State of Maryland / Department of Health and I 1- State Amend Item 10d per Verb, G842, 04/08/05dhb Ragistrar Certificate of Death		ene 004	42919
		Decedent's Name (First, Middle, Last)	2. Date of Death Month		3. Time of Death
Physic /Med		LA VERN WHITE	Decemb	25, 2cm	(
Exami	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PANINGUIA ROADSHOL MARKET CLARE SALISBURY	1	4c. County of Dear	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	rear)	thplace (State or Foreign
Director		215 - 58 - 5608 1 M 20 F 53 Yrs. World Cays 1 No. 1 W 20 F 53 Yrs. World C	12-21	7-51	MD
aryland show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 🗓 No
the Ma 28e-f s	ecto	10e. Street and Number 10f. Zip Code)	10	g. Citizen of What Co	
3a or 3	οir	4505-ALLEN RD 21801			5A
r death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel", or Items 23a or 28e-f show event, it a Madical Everther print to mailthead.	by F.	1 Never Married 2 Married 1		Specify: B	LACK
72 hou nature		15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of work	kina 1	6b. Kind of Business	-
within 308.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		WCDSS	
Hygie other	Be Co		ne (First, Middle, M	aiden Sumame)	\
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Vicinity Vic	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru		o manifero mano	Zip Code)
s t and f Health item 27 other tr		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	ALISBURG Date	c. Location - City or	Town, State
Pages nent of ent: If it ury or o		SPRINGHILL CEM. 1-8	7-05 f	LEBRON,	MD
portrillioie, Man yially A.I.A.I.S.COOOO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-1 show any injury or other treumatic event. Ite Medical Ever it set must be neutilized any once.	(BENNIE	SMITH	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Mp 2188) Approximate Interval Between
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Subarachusid hemorrhage			Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of):) = 1073
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
cuted nd transit	Examiner	that initiated events c.			
icate be executed physiclan and sthe burial-transit	ai Ex	resulting in death) Last Due to (or as a consequence of):			
ificate g phys	edicai	d			
th cert tendin	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of del Month	ivery Day Year
v requires that the death certific been signed by the attending f should be detached for use as	Physician/Me	1 □ Pes 2 □ No 9 □ Unknown 5 □ Other (specify)		Work	Suy Tu.
s that I	by Ph	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
w require			1 🗆 Yes	: 2 No 3 ₽r	obably 4 Unknown
e law r has be	Completed		24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
elcien: The law s certificate has b lirector, page 2 s		25. Was case referred to medical 26. Place of Dea		No 1 □ Yes	2□ No
nyelcie nis cert	To Be	examiner? 1 Yes 2 No		ice 6 Other (Spe	cify)
ing Pl		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Nestidation investigation 28a. Date of Injury 28b. Time of 19 Nork? 1 Yes 2 No	28d. Describe hov	v injury occurred	
Attence death death sector:	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru	ural Route Number,
itel or its afte ral Diri	Cert	4 ☐ Homicide building, etc. (Specify)	City of Tawn,	State)	
To the Hospilel or Attending Phyelcien: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 minutes of my knowledge, death occurred at the time, date and place 2 minutes of my knowledge, death occurred at the time, date and place 2 minutes of my knowledge, death occurred at the time, date and place 2 minutes of my knowledge, death occurred at the time, date and place 2 minutes of my knowledge, death occurred at the time, date and place 2 minutes of my knowledge, death occurred at the time, date and place 2 minutes of my knowledge, death occurred at the time, date and place 2 minutes of my knowledge, death occurred at the time, date and place 2 minutes of my knowledge, death occurred at the time, date and place 2 minutes of my knowledge, death occurred at the time, date and place 2 minutes of my knowledge, death occurred at the time, date and place 2 minutes of my knowledge, death occurred at the time, date and place 2 minutes of my knowledge, death occurred at the time, date and place 2 minutes of my knowledge, death occurred at the time, date and place 2 minutes of my knowledge, death occurred at the time, date and place 2 minutes of my knowledge, death occurred at the time, date and place 2 minutes of my knowledge, death occurred at the time, date and d	, and due to the cat rred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
To the within To the comple	Me	29b. Signal re and title of certifier 29c. License number	29	d. Date signed (Monti	h, Day, Year)
. 0 0)		D57331	De	cember 29	1,2004
2 du		29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thirdy H. P. e. Re. 560 R. V. S. de. D. R. Suite A- 31. Date filed (Month, Day, Year) DEC 3 0 2004 Annua A Aparks	102 Salah	wine ind	21901
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	211102	- Jina	· XII/
Regis	trar	DEC 3 0 2004 Anna B sparks			

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
State of Maryland / Department of Hea	

			1 - For State Registrar	State of Mar		artment of F					
	Physici		Decedent's Name (First, Middle, Last Elizabeth	Ann	Watson			2. Date of Dea Month Dec•) () () 004	3. time of Death
	/Medi Examir		4a. Facility Name (If not institution, give Salisbury Nursing	e street and number)		4b. City, Town, or	Salisbu	th	4c. County		11001
	Funeral Director		5. Social Security Number 6. S 220-01-9505		n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	1	9. Birthp	place (State or Foreign offin) Yland
	Maryland -1 show fied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Wicomic	1	Oc. City, Town or Lo					1	0d. Inside City Limits 1 XYes 2 □ No
	3a or 28e	Funeral Director	10e. Street and Number 200 Civic Avenu	ie.		10f. Zip Code 2180	11		10g. Citizen of USA	What Cour	itry?
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or Items 23a or 28e-1 show event, the Medical Examera must be notified at	by	11. Marital Status 1 Never Married 2 Married 3XXVidowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba		specify Yes or No- to Rican, etc.)	14. Rad Bla	ce - Americ ck, White, y: Whit	etc.
2121	C 2	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done o DO NOT use retired SEWITE	during most of wo		16b. Kind of B	stic	lustry
Maryland	should be filed withir and Mental Hygiene. I marked other then umetic event, the Mental and the	To Be	17. Father's Name (First, Middle, Last) Basil William Hea				Katie	ne (First, Middle, Lena Go	dwin		
	is 1 and 2 should of Health and Menitem 27 is marker other treumetic		Janice W. Ada 20a. Method of Disposition	ms/Daught	er 515	E. Gord	dy Rd.	Salisbu	ry, MI	218	304
altimore,	Page nent o ent: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☒ Other (Specify 27. Signature of Funcial Service Licen.	Entombment	Wicomico		1/5	/2005	^{20c. Location} - Salisbu	ry, M	ID
Ba	permit. Departi		Ravie Ho Chon	MODAL C	7	Name and Address OLLOWAY F 01 Snow H	TTT KG.	Salisbu	CV. MID	1 Ass 21804	ociation
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	but cause on each line. Due to (or as a co	to	Level of aying	g, such as cardiad	Sor respiratory arri	est, a do	ZIAR	Approximate Interval Between Onset and Death
8/60,	icate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cc Due to (or as a cc d.		yord				- /	reary
O. Box 6	death certif e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dati Mor	e of deliver	y Day Year
cords, P	w requires that the been signed by the should be detached	by	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the un	iderlying cause give	n in Part I.		acco use contr		e cause of death?
Ž	The law ate has b page 2 sl	Completed						24a. Was ar autops perform	negz d	Vere autoporior to comileath?	sy findings available pletion of cause of
DIVISION OF VITAL	ending Physicien: The sath. or: After this certificate he funeral director, pag	ation: To Be	27. Manner & Death 1 Matural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Injury Work	r. 4 Nursing Ho	th (Check only one ome 5 Reside 28d. Describe ho	nce 6 Othe	er <i>(Specify)</i> ed	
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	l Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	pecify)			28f. Location (Str City or Town	State)		
	To the Hos within 24 ho To the Fun completely (Medical	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exemi	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	occurred at the time estigation, in my opi 29c. License	nion, death occur	red at the time, da	te and place, a	nd due to t	he cause(s)
	8784		Ver Au	The second secon	/ltom 00=1 C	02	-934	9 29	d. Date signed	(WORLD, D.	1y, 18ar)
	Sta	0	30. Name and address of person who compared to the street of the street		CIVIC AVE	·,SALISBU	RY, MD.	21804			
	Sta Registra		JAN 042	005	. K A	nasti)					

		i icus						Mental Hygie	_	
		1 - For State Registrar	Olale 0	i waiylai		rtificate of			2004	42921
		Decedent's Name (First, Middle,	Last)			timouto or	Dodin	2. Date of Death	<u> </u>	3. Time of Death
Physic /Medi		Dora Jane	Willey	7				December	3i 200	+ 02:13 R
Exami		4a. Facility Name (If not institution,			1 1	4b. City, Town,	or Location of Death		4c. County of Dea	th
			gional M	redical	Center	Sa	lisbury		Wilon	ico
Funeral		5. Social Security Number	. Sex 1 ☐ M 2 🖫 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y	(ear) 9. Bir	thplace (State or Foreign ountry)
Director		213-22-9099 Usual Residence of Decedent	A	77	(13.			November 6	, 192/ Mar	ryland
yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
Mar a-fst	tor	Maryland Wicomi	co	Sa	alisbur	v				1 ☐ Yes 2 💢 No
death with the Maryland ms 23e or 28e-f show r i ust be notified at	Director	10e. Street and Number				10f. Zip Code		100	. Citizen of What Co	ountry?
ath w		30536 Bennett Ro	pad			21804			USA	
er de Items	Funeral	11. Marital Status	Armed Fo		.S. 13. \	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (S oan, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
rs after	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	d 1 □Yes If Yes, Giv Year or D	/e		1□ Yes 2🌠 No	Specify:		Specify:	talls it a
d Z IZ 13-003 filed within 72 hours Hygiene. ther than "naturel", ant, the Modical Ex-		15. Decedent's	Education		16a. Deced	dent's Usual Occu	pation	16	6b. Kind of Business	White /Industry
Phin 7	ple	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1	I-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wor ed)	king		
ed wi	Completed	6			House	wife			Homemake	er
be fill that H doubt	Be	17. Father's Name (First, Middle, La					18. Mother's Nan	ne (First, Middle, Ma	iden Sumame)	
y Ich	2	George Willia		sons	105 14-18-	A 14 /O:	FLossie			
d 2 sl d 2 sl th an th an treur		19a. Informant's Name/Relationship		,	Paragraph re			ral Route Number, C		4p Code)
DAILITIOFE, INIGITY IGITIO Z 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than "naturel", or Items 23s or 28a-f show any injury or other treumatic event, the Madical Examinational be notified at once.		Richard Lee Will 20a. Method of Disposition	-	20b. F	Place of Dispo	ickory T sition (Name of	ree Drive	Georget Date 20	c. Location - City or	
DEMILITION Permit. Pages Department of I mportent: If It any injury or o		1 X Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe	Removal from	State	,	natory`or other pla	1	4 000		1 2 12
Dalling permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Lic		Stri	22	Name and Addre	ace of Eacility	y 4, 2005		
B F F F B		David 94. 1	amos	mo CF	SP 5	olloway	Funeral H	Home Profe	ssional A	ssoiciation
35		23a. Part 1. Enter the disease, or co shock, or heart failure. List or	implications that c	aused the deat	h. Do not ente	or the mode of dyi	ng, such as cardiac	or respiratory arrest	ry, Maryı	Approximate Interval Between
Pnysician		Immediate Cause (Final disease or condition		GESTIV		ART FA				Onset and Death
/Medical		resulting in death)		or as a conseq	C1-1-1	The tr	ILVKE			142
Examiner	١.	Sequentially list conditions.	b. Col			ERY DIS	EASE			
ad sit	ine	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	·	or as a conseq		^		1		
be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last		or as a conseq		L REGU	6 TATION	J		
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	calE		· ·	VERE		Iani AO	HYPERTE	lagrala		YVS
ficate ficate phys			d	, , ,		1	III I THIC	10 14 6/6		1
Physicien: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			ie .			23d. Date of del	ivery
death death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregn	irth 2 ☐ Feta ant at time of d		Ectopic pregnanc Other <i>(specify)</i> _	·y		Month	Day Year
by th	hys	9 Unknown	9□ Unkno							
es tha	by §	Part II. Other significant conditions	_	eath but not res	ulting in the ur	nderlying cause gr	ven in Part I.			the cause of death?
law requires las been signe	ted	SCIERODEF				\		1 L Yes	2 No 3 Pr	obably 4 Ednknown
e law has b	Completed	SEVELE TR	1 CUSPID	REGU	RUTA	LLOL		24a. Was an autopsy	prior to d	topsy findings available completion of cause of
The lave cate has	S							performe		2 🗆 No
vicion: Th icion: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	/		0#	hac	th (Check only one)		
ding Physicien: h. After this certific funeral director,	1: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date o		ER/Outpatien 28b. Time of	t 3 DOA 28c. Inju	4 Nutsing H	ome 5 Residence 28d. Describe how		oify)
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lor Attending after death. Director: After in by the fune	Certification	3 Suicide 6 Could not	t be 28e. Place	of Injury - At ho	ome, farm, stre	eet, factory, office			et and Number or Ru	ural Route Number,
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical (29a. Certifier 1 Certifying	aminari On the hi	seie of avamina	tion and/or in-	continuation in con-	animina danth annu	, and due to the caus	and alone and disc	stated.
ths F nin 24 the F	Medi	oney	and man	ner stated.		Ostigation, in my (opinion, death occul	nou at the time, GATE	and place, and due	
Viit To	Σ	29b. Signature and title of certifier				29c. Licens	se number	29d.	Date signed (Month	i, Day, Year)
100		Tolor	1			•	41311		143110	4
100		30. Name and address of person wh	Completed caus	e of death (Item	23a) (Type, I	Print)	hore Dr	5461364	W MO	
Ct.	ate	31. Date filed (Month, Day, Year)	32. P	istrar's Signa	iture	-	/		/	
Regist		JAN na	2005	Palue .	K A	souls?		29d. 29d. 29d. 3 DC/35b4		

DORA 213-5

attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760 P.O. the þ signed b Division of Vital Records, certificate has this

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 31, 2004 Physician 1:20A M HILDA EVELYN WHITE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Worcester Berlin Nursing & Rehabilitation Center Berlin 7. Age (In yrs. last birthday)

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
Sept. 21,1922 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 KF Director 82 MD 218-16-8815 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 27 is marked other than "natural", or Items 23a or 28e-1 show treumatic event, the Medical Examinar must be notified at MD Worcester Berlin 1 Yes 2 XNo Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9715 Healthway Dr., 21811 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 | Yes 2 | No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edith Pearl Clark Ollie Bailey 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 i 7283 Main St., Willards, Md. 21874 Benjamin Lawrence White (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Friendship United Methodist Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Importent: If Its any injury or or once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan.4,2005 Willards, Md. 22. Name and Address of Facility 21. Signature of Fune Fervice Licens The Burbage Funeral Home 108 William St., Berlin, Md. 21811 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final asoliovascula-Physician neroscherotic TERRY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Ecus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dual (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 40 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Walursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 0 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After 5 Pending investigation 1 Natural М 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Pay, Year) certifie 29c. License numbe 29b. Signature 28769 164 hwa ne and address of person who completed cause of death (Item 23a) (Type, Print) 5 Mules odulla 32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 03 State 2005

Registrar

DESCES.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health Mental Hygiene 1- State Registrar]-6-05 Amend #12.Per FH PCC cr Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 21,2004 **Physician** Timothy Walker Washington, Jr. 23:48p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince Georges 6713 Summerhill RD Temple Hills If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □XM 2 □ F 578-88-1520 October 30,1958 Director Bellevue, PA 46 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f ahow It e Medical Exspirer must be notified at Y Yes 2 □ No ō MD Temple Hills Prince Georges Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 6713 Summerhill RD. United States death v Funeral 12. Was Decedent Ever in U.S. Amed Forces? 6/9/1982 1 Wyes 27 No. If Yes, Give Year or Dates:6/8/1985 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2XXNo Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Printer Private othar traumatic avant, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or othar traumatic avant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Timothy W. Washington Sr. Rose E. Thompson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lorraine C. Washington /Wife 6713 Summerhill Rd., Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem 12-30-04 Cheltenham, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility S. Pope Funeral Home 5538 Marlboro Pike, Forestville, MD 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 6 months Metastatic Cancer Rectum /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) attending physician Box 68760 certificate be Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No 24a Wasan certificate has Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 □ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 XResidence 6 Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Diractor: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide ō within 24 hours 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 D24052 December 28, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 106 Irving Street S-2200 Washington, D.C. McKnight, John Ε. 20010 2. Registrar's Signatur 31. Date filed (Month, Day, Year) State JAN 0 3 2005 Registrar

		1 - State Registrar	State of Maryland		tificate of E			2 0 0 4	4292
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Funeral Director		5. Social Security Number 6. Social Security Number 1	ex 7. Age (In yrs. last □ M 2▼F 91	t birthday) Yrs.				(, Year) 9.	Birthplace (State or Fo Country)
2		Usual Residence of Decedent					THAT CIT J	, O , 1) 1 J	ashington
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28a-f	Director	Md Prince 10e. Street and Number	Georges Beav	er He	ights				Yes 2
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and Mental Is marked o raumatic eva		19a. Informant's Name/Relationship (7						; City or Town, State	
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Department of Important; If is any injury or once.		21. Signature of Funeral Service Licens	1080	²² / _A	Name and Address Lexander 38 Marlb	of Facility S. Pope oro Pike	Funeral Forestv	Home ville, Md.	20747
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 4 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth Month Day 22 Physician 2004 Donald Bell Winslow December 8:06 AM /Medical 4b. City, Town, or Location of Death 4a Fecility Nema (If not institution, give street end number) 4c. County of Deeth Examiner Prince George 12717 North Cliff Road 7. Age (In yrs. last birthdey) If Under 1 Year 9. Birthplace (State or Foreign North) Carolina Social Security Number **Funeral** Months Days 214 30 0098 1XXM 2□ F 71 Yrs Director Usuel Residence of Dacedant 10a. State 10c. City, Town or Location 10b. County 10d. Insida City Limits 1 ☐ Yes 2 ☑ No **Funeral Director** MD Prince George Bowie 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 20720 12717 North Cliff Road USA 12. Wes Decedent Ever in US2— Armed Forces? 1952— YBYSs 2□ No 1954 Yes, Give Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indian. Black, White, etc. 1 Naver Married 2 Merried 1 Tyes 2 No White Specify. Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Government Printing Elementery/Secondary (0-12) College₁(1-4or 5+) Printer Office 17. Fathar's Nama (First, Middle, Lest) 18. Mother's Nama (First, Middla, Maiden Surnama) Maywood Preston Winslow Mary Brock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rurel Route Numbar, City or Town, Stata, Zip Coda) Nancy Winslow (wife) 12717 North Cliff Road, Bowie MD 20720 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/23/04 Alexandria VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune of Service Licenses 22. Nama and Address of Facility
Advent Funeral and Cremation Services Falls Church VA and Annapolis MD 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Daath Physician Immediata Causa (Final disease or condition resulting in death) /Medical ampullary Cancer

Dua to (or as occused uence of): Examiner Examiner To the Hospital or Attending Physician: The law raquiras that the death certificate be assected within 24 hours state deeth.

To the Funeral Director: Atten this certificate has been signed by the attending physician and complately filed in by the Innered insector, page 2 should be detached for use as the burlar-transit Sequentially list conditions, if eny, laeding to immadiate cause. Enter Undarlying Cause (Disease or injury that initieted events resulting in daath) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequance of): Part II. Other significant conditions contributing to death but not resulting in tha underlying causa givan in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1L Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 M Rasidance 6 ☐ Othar (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28d. Dascribe how injury occurred 5 Panding invastigation 1 Neturel 1 ☐ Yas 2 ☐ No 2 Accidant 6 ☐ Could not be detarminad 3 Suicide 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Numbar or Rural Route Numbar, City or Town, Stete) 4 Homicide 29a. Certifier 156 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of 12-22-04 DC 19655

State Registrar

DHMH 16 Rev 6/95

3800 Reservoir Road NW

Washington DC 20007

30. Name end eddrass of person who completed causa of death (Itam 23a) (Type, Print)

32. Resistrer's Signatura

John L. Marshall, M.D.

DEC 29 2004

31. Dete filed (Month, Day, Year)

			State of Maryland / Department of Health and 1- State Amend Items 10d, 19a, 23, 25 per Confidence of Maryland / Department of Health and 1- State Amend Items 10d, 19a, 23, 25 per Confidence of Maryland / Department of Health and 1- State Amend Items 10d, 19a, 23, 25 per Confidence of Maryland / Department of Health and 1- State Amend Items 10d, 19a, 23, 25 per Confidence of Maryland / Department of Health and 1- State Amend Items 10d, 19a, 23, 25 per Confidence of Maryland / Department of Health and 1- State Amend Items 10d, 19a, 23, 25 per Confidence of Maryland / Department of Health and 1- State Amend Items 10d, 19a, 23, 25 per Confidence of Maryland / Department of Health and 1- State Amend Items 10d, 19a, 23, 25 per Confidence of Maryland / Department of Health and 1- State Amend Items 10d, 19a, 23, 25 per Confidence of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department	Mental Hygid	ene 004	42926
E	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month		3. Time of Death
	/Medic	al	Lawrence Brown Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	ARCENIDE	4c. County of Deat	7 9
		<u>.</u>	Mary and General Hospital Baltimore (5. Social Sedurity Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hir	s. 8. Date of Birth	N/	hplace (State or Foreign
	Funeral Director		25.12.4447 18M 20F 83Yrs. Months Days Hours Mir		(Par) 921 Co	SC.
	aryland show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	<u> </u>		10d. Inside City Limits
	he Mar 28a-1 sh otified	ector	MD N/A Baltimore 10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	1 X Yes -2 X No
	23a or	ai Dir	301 McMechan St. Apt. 705 21217		U.S.	A
	ter dea r tams	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
	be filed within 72 hours after death with the Maryland tal Hygiene. Ad other than "natural", or Itams 23a or 28a-f show evant, the Medical Examinar must be notified at	þ	3 ☑ Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 ☑ No Specify:		Specify: B	ACK
5	hin 72 l e. an "nati Medice	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of w	orking	6b. Kind of Business	nem Steel
, אר היי ה	filed wit Hygiene ther the	e Con	12th grade NA MACHINE OPERA	ame (First, Middle, Ma		Rem Sect
Jali	should be filed ind Mental Hygi s markad other umatic evant, I	To Be		. Mae Sn	nith	
Mar	d 2 sho th and th and 27 is mu trauma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or II 19b. Mailing Address (Rural Route Number, d. PIKESI	11 110	zip Code) 21208
e e	ges 1 and 2 should be filed within 72 hours after death with the Maryla, tof Heatin and Mental Hygiene. A the firm 21 is marked other than "natural", or Itam 21 as or 28a-1 show or other traumatic event, the Medical Examinar must be notified at		20a. Method of Disposition 20b. Place of Disposition (Name bf cemetery, crematory or other place)	Date 2	0c. Location - City or	
	ant Ind		14 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensed 22. Name and Address of Facility Vaughn C. Creene	.22.04	Divings Illi	ILS MD
0	permit. Departr Imports any inju		55 JBaltimore Nas	tional Peke	- builtimer	
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi shock, or hearn failure. List only one cause on each line. Immediate Cause (Final disease or condition	ARIC Con	1 1	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):	inac con		
Į		Jer	Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying	All	IER .	
	be executed ician and burial-transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	ED BY MEDICAL EXAMIN	4C1	
2/00	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical E	Due to (or as a consequence of):			
POX PO	death certificate e attending phys d for use as the		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant		23d. Date of de	ivery
o o	e death the atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Month	Day Year
ř.	law requires that the as been signed by th 2 should be detache	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
coras	require seen sig hould b		Ischemic Caraiomyopariy, 3/P			obably 4 Dunknown
Y Y	The law ate has t page 2 s	ompieted	prostatie biopsy	24a. Was an autopsy perform	prior to	topsy findings available completion of cause of 2 No
VItal	i ician : The lav certificate has rector, page 2	BeC	examiner?	eath (Check only one)	
0	ig Phya ter this neral dii	on; To	1 X Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Over 4 Nursing 27. Manner of Leath 1 X Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	Home 5 Resident		city)
DIVISION	uttendir death. ctor: Al y the fu	ertification;	Accident investigation M 1 Yes 2 No 3 Suicide Solution to be added to be a suicide Solution to b		eet and Number or Ri	ural Route Number,
2	ital or / irs after ral Dire	0	4 ☐ Homicide usternmed building, etc. (Specify)	City or Town,	State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla (Check only one)	ce, and due to the cau curred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier 29c. License number		d. Date signed (Mont	h, Day, Year)
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elarne FRUZIER, M.D. 40 Maryland General	1/2 1	70107	
	Sta	ato	31. Date filed (Month, Day, Year) 32. Registrar's Signature	NOSPITE	al	
	Regist		JAN 1 8 2005 Feet & South			

DHMH 17 Rev 1/2001

ORIGINAL

			For Amend Items Stata Registrar	State of Maryland 25,27,28a-f per	/Departmen ME G839,0 Certificat	t of Health at 1718705dfil e of Death	nd Mental Hyg	iene	10007
	9		Decedent's Name (First, Middle, L.	ast)			2. Date of Deat		6. Time of Death
	Physici /Medio		KOSE	BANZ			17-	72-7006	4 410 PM
	Examir	er	4a. Facility Name (If not institution, g	1	4b. City,	Town, or Location of		4c. County of Dea	th
			5. Social Security Number 6.	Sex 7. Age (In yrs. las	t birthday) If Under	TIMORE 1 Year If Under 24		9. Biri	thplace (State or Foreign
	Funeral Director		2110-12-3343	10M 200/F SL	Yrs. Months	Days Hours	Min. 8. Date of Birth (Month, Day,		EYLAND
	p.		Usual Residence of Decedent	100 Cit. 3					10d. Inside City Limits
	Maryland -f show	'n	10a. State 10b. County	noc. City,	Town or Location				1 Yes 2 No
	the Marylan 28a-f show	Director	10e, Street and Number	MORE	10f. Zip	Code	1	Og. Citizen of What Co	
	th with the 23a or 28a ust be noti	0	8910 Avond	ale Rd.		21234		1)5A	
	itams 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dece	dent of Hispanic Original	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, Whit	
36	g 0 E		1 Never Married 2 Married	1 □Yes 2 No	1 ☐ Yes	Le .		Specify: //	hida
5-0036		ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	16a. Decedent's Usua	al Occupation		16b. Kind of Business	Andustry
215	in 72 n "na	Completed	(Specify only highest g		(Give kind of wo life. DO NOT us	rk done durina most d	of working	O I	modely
212	led within lygiene. har than "	Com	2 (0-12)	College (11401 34)	Bookke	eper		Caterino	-
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las	(31)		18. Mother's	s Name (First, Middle, I	Maiden Sumame))
yla	should be filed withir nd Mental Hygiene. marked other then imatic event, ILE Ma	P	Harold >	· DaTTES	40h Mailine Address	LO1	rretta	oiles	Zin Codo)
Maryland	2 8 8		19a. Informant's Name/Relationship	noz busha	A L	(Street and Number	or Rural Foute Number	City or rown, state, 2	21234
	s 1 and of Health item 27 other to		20a. Method of Disposition	COTT	ce of Disposition (Nar netery, crematory or o	me of	Date	20c. Location - City or	Town, State
E 0			1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Hemoval from State	was Con	10-614 11	-210-04	PARKVIlle	MA
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Lic	ensee	22. Name ar	nd Address of Facility	BALTIMOR	The state of the s	f
	207 29		Kimberly L	1. gut other	EVANS	S FUNERAL	CHAPEL S	8800 HARFE	
			-	mplications that caused the eath. y one cause on each line.				est,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Subbull		MATULLA	L		
	Examiner			Due to (or as a conseque	nce or):				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequer	nce of):			15.75	
	kecuted and I-transi	Examiner	Cause (Ultrease or injury) that initiated events resulting in death) Last	c			1/1/	we to	
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687		edlo		d		CERTIFICATION AP	PROVED BY MEDILIPE		
Вох	death certifica e attending ph id for use as th	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de		CERTIFIC. V		23d. Date of del	*
	0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐ Pregnant at time of deat				Month	Day Year
P.0	that the di ed by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions		ng in the underlying o	ause gwen in Part I	23e Did toh	pacco use contribute to	the cause of death?
ds,	es pe pe	d by	ratii. Othor algimount somations	Contributing to about but not result	ng in the diadriying e	adde given in rait i.	1 □ Ye	1.7	robably 4 Unknown
Records,	> 0 0	Completed					24a, Wasa	n 24b. Were au	itopsy findings available
Re	The lav ate has page 2	dwo					autops perform 1 ☐ Yes 2	y prior to death? Death? 1 ☐ Yes	completion of cause of
Division of Vital	ician: Th certificate ector, pag	0	25. Was case referred to medical			26. Place o	of Death (Check only on		2010
) \	ys dir	To B	examiner?		VOutpatient 3☐ DC	OA Other: 4 Nurs	ing Home 5 Reside		cify)
o uo	fter ne	lon:	27. Manner of Death Satural 5 Pending	(Month, Day Year)	Bb. Time of 2 Injury	28c. Injury at Work? 1 ☐ Yes 2 🛣 No		w injury occurred	
isio	Attanding r death. sctor: After y the fune	Certifications	2 X Accident investigati 3 ☐ Suicide 6 ☐ Could not	11/20/2004	nknown ^M e, farm, street, factor		28f. Location (St	reet and Number or Ru	ural Route Number.
Οį	al or A after 1 Dire d in b	erti	4 Homicide determine	28e. Place of Injury - At home building, etc. (Specify)			8910 Ave		MD 1.Parkville
	ospita hours unera ly fille	cal	29a. Certifier Certifying I	Physician: To the best of my knowle aminer: On the basis of examination	edge, death occurred	at the time, date and	place, and due to the ca	use(s) and manner as	stated.
	To the Hospital or Attandin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one)	and manner stated.	-				
	Con	~	29b. Signature, and title of certifier	0 16 -	290	c. License number		9d. Date signed (Monta	
/	(10)		30. Name and address of person wh	o dompleted cause of death (Item 2)	3a) (Type Print)	14400		11 11 200	14
,			K. Kelly, MO			STREET,	BACTEM	DEF MO	04
	Sta		31. Date filed (Month, Day, Year)	HIG (V KG	Ana. M.		,	*	
4	Registr	ar	JAN 1 8 200	I PHERON ST.	Moser				

		Amend Item 23a	State of Maryland / per Dr., G839,01	Department of I 1/20/05dhb Certificate of	lealth and M Death		ene 1. No. 2004	1,2928
	Physician	Decedent's Name (First, Middle, Last				Dete of Deeth Month	Dey Year	3. Time of Death
-	/Medical	Tonja Geriinda i					29 2004	11:15 AM
,	Examiner				4b. City, Town, or Lo	cation of Deeth	4c. County of Death	
		Lorien Nursing &		hirthday) If Under 1 Year	Columbia If Under 24 Hrs.	O Date of Birth	Howard	lana (Chata as Fassias
	Funeral Director	212-80-0609	7. Age (In yrs. lest)	Yrs. Months Deys	Hours Min.	8. Date of Birth (Month, Day, Y Feb. 13,	(ear) 1959 DC	lace (State or Foreign try)
	pug ≱	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location			1	0d. Inside City Limits
	Menyl short	MD Anne Aru	ınde1	Glen Burnie				1 ☐ Yes 2 ☐XNo
	vith the Mer or 28a-f si be notified	10e. Street end Number		10f. Zip Code		10g	. Citizen of What Cour	ntry?
	ath with the Merylen (23e or 28e-f show	1315 Cory Drive		21	061		U.S.A.	
020	urs efter deall, or fleme	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:	13. Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
21215-0020	c * 61 =	15. Decedent's Edu (Specify only highest great Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	Ge. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Master Barbe	during most of worki d)	ng 16	b. Kind of Business/Inc	dustry
9	建工名员 a			Inducti Barbe		(First, Middle, Ma		
Maryland	S S S C	Larry Wilson			Betty	Lou Chur	ch	
ary	2 should end Men is marke aumatic	19a. Informant's Name/Relationship (T)	rpe, Print) 1	9b. Mailing Address (Street	and Number or Rure	l Route Number, C	City or Town, State, Zip	Code)
	tra is	Mr. Kenneth Buckle	ey / husband	1315 Cory Dr	ive, Glen	Burnie,	Maryland 2	1061
Baltimore,	50 50	20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐F	temoval from State	of Disposition (Name of tery, crematory or other place and Veterans	Cem J;	an 3	c. Location - City or To	
를	permit. Pege Depertment of Important: If any Injury or once.	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	-	22. Name and Addre				
Ba	Depe impo	1. Coul	V. mo1319	1 Second A	311		uneral Hom Burnie, MD	
1	Physician	23a. Tart1. Enter the disease, or complete shock, or heart failure. List only o	ications that caused the death. Dine cause on each line.	o not enter the mode of dyir	ng, such es cardiac c	r respiratory arrest	\$ 8 1	Approximate Interval Between Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Chronic Due to (or as	Lenal fair	live		1	
	ال الله م	_	Hypertens	sion			1	
	executed in end iel-trensit	Sequentially list conditions, if any, leading to immediate	Due to (or as	а соповушенов оп.				
9	clan clan ouriel	cause. Enter Underlying Cause (Disease or injury	Diabetes	Mellitus				
k 68760,	death certificate be executed ettending physician and of or use as the buriel-transit stclan/Medical Examin	that initiated events resulting in death) Last	Due to (or as a	a consequence of):			1	
Вох	et the death certification of the ettending of the ethod of the etho					Land town		
0	by the e	Part II. Other significent conditions con	ntributing to death but not resulting	in the underlying cause give	en in Pert I.		ecco use contribute to	
о.	requires that the seen signed by the should be deteched by Physelect b					1 🗆 Yes	2□ No 3□ Prot	pably 4 Unknown
of Vital Records,	N S S					24a. Was an a performe	d? ava	ere autopsy findings ailable prior to mpletion of cause deeth?
Ě	The law ete hes by page 2 s					1 ☐ Yes	2X No 1 E	Yes 2 No
Ta	certificate rector, pag				26. Place of Death	(Check only one)		vi.l
<u>></u>	\$ 50 E	1 ☐ Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/0		4 Li Nursing nor	ne 5 🗆 Residend		Center_
	Attending Planding Pl	27. Manner of Deeth 1 Netural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year) 28b	. Time of lnjury Mor	yat k? Yes 2 □ No	28d. Describe how	injury occurred	
Division	tal or Attending Presenting Present. In Director: After the in by the funeration: Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	1	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	To the Hospital or Attending Ph within 24 hours efter deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best of my knowled ner: On the besis of examination of and manner stated.	ge, death occurred at the tir end/or investigation, in my o	ne, date end place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
_	Vithin Forth	29b. Signature end title of certifier		29c. Licens			. Date signed (Month,	•
		*	MI)	Di	053709		12/29/0	4
	10	30. Neme and eddress of person who co	Aw LA 3060	mitchell Vill	e rd	Bowie	12/29/0	20716
	State Registrar	31. Date filed (Month, Dey, Year)	AW LA 30 60 32. Registrer's Signature	back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#23a(b) perMD 6839 1/14/05 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 4 U 0 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Johnnie Baxter 6:20 p. M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 3627 Rosedale Road Balto If Under 1 Year Months Days If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex **Funeral** Min Months 1 XM 2 ☐ F Hours 85 S.C. Director 251-01-0709 10-13-1919 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland ent of Heath and Mental Hyglene. And the file 27 is marked other then "neturel", or Items 23e or 28e-f show any or other treumatic svent, the Medical English entitled any or other treumatic svent, the Medical English entitled at 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b County 1 SyYes 2 □ No N/A Director Md Balto 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21215 3627 Rosedale Road S Α Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: If Yès, Give Year or Dates: **Black** þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U. S. Post Office Letter Carrier 12th grade 1 year 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Artimus Baxter Lugenia Stokes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sandra Baxter - Daughter 3627 Rosedale Road Balto, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department of Importent: If it any injury or o Garrison Forest Vet 12/30/2004 Owings Mills, Md Donation 5 Other (Specify) 22. Name and Address of Facility March F/H West 21. Signature of Fundal Shrvice Licensee 4300 Wabash Avenue Balto, Md 21215 23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neuman Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Listage or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 □ Yes 2000 3 Probably 4 Unknown Completed Kinson's disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 Yes 2 No Division of Vital Hospitel or Attending Physiclen: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funerel I filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) mpletely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 (Item 23a) (T gistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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2005

		1 - For State Registrar	State of Maryla	nd / Dep		lealth and	Mental Hygi	_	+ 4293
Physici /Medic Examir	al	Decedent's Name (First, Middle, L. Virginia L. Bo Vanginia L. Bo Aa. Fecility Name (If not institution, girls)	wler		4b. City. Town, c	r Location of Dea		Day Year 27, 2004	
Funeral Director				s. last birthday; 7 Yrs.		If Under 24 Hrs Hours Min		Anne Aru (ear) 9. Birtl Co 1927 Was	hplace (State or Foreigr untry) hington DC
the Maryland 28a-f ehow cutfied at	Director	10a. State 10b. County MD Anne Aru 10e. Street and Number		Cro	ocation ofton		100	g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Identy identified within 72 hours after death with the Maryland and Mental Hygiane. Is marked other than "natural", or Items 23a or 28e-f ehow aumatic event, the Medical Evaninal must be notified at	by Funeral Dir	1830 N. Forest 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Court #C 12. Was Decedent Ever in Amed Forces? 1 Yes 2 PNo If Yes, Give Year or Dates:			21114 lispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No- tto Rican, etc.)	USA 14. Race - Amer Black, White	rican Indian,
ithin 72 hounder.	Completed	15. Decedent's Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo d)	orking	6b. Kind of Business/l	•
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permit. Pages 1 and 2 should Department of Health and Man Important: If Item 27 is marke any injury or other traumatic.		19a. Informant's Name/Relationship Brent Ruhkamp/tr 20a. Method of Disposition 1 Burial 2 Cremation 3 5 4 & Donation 5 Other (Speci	ustee 20b.	1032		e Nation	nal Pike E	City or Town, State, Z 11icott Ci Oc. Location - City or 1	ity, MD 210
permit. P Departme Importan any injuri		21. Someture of Funeral Socice Lice Ronald S			2 Name and Addre tate Anat altimore,			Baltimore	Street
Physician /Medical		23a. Part 1. Enter the disease, or consheck, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the de one cause on each line. a. Hypoxia Due to (or as a conse	eth. Do not en	ter the mode of dyu	g, such as cardia	c or respiratory arres	t,	Approximate Interval Between Onset and Death ZH Mrs
ate be executed by the burial-transit	cal Examiner	Sacuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Lo (or as a consecutive to consec	equenc= o): UMCU	2 dema r				48 hr
ath certifica attending ph for use as t	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	tal death 3	□Ectopic pregnancy	,		23d. Date of delin	very Day Year
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ng Phys ter this neral di	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	er: 4 - Nursing I	ath (Check only one) Home 5 Resident 28d. Describe how	ce 6 Other (Specinjury occurred	ify)
pital or Attending Phys ours after death. eral Diractor: After this of filled in by the funeral dir	I Certification:	3 Suicide 6 Could not be determined	building, etc. (Spec	cify)		no doto	City or Town,		
To the Hospital or A within 24 hours after To the Funeral Dirac completely filled in by	Medical	29b. Signature and title of certifier	hysician: To the best of my kr minar: On the basis of examir and manner stated.	nation and/or in	29c. Licens	pinion, death occi	urred at the time, date	se(s) and manner as a and place, and due	to the cause(s)
Sta Registr	- 1	30. Name and address of person who the idea of the same and address of person who are idea of the same and address of person who are idea of the same and address of person who are idea of the same and address of person who are idea of the same and address of person who are idea of the same and address of person who are idea of the same and address of person who are idea of the same and address of person who are idea of the same and address of person who are idea of the same and address of person who are idea of the same and address of person who are idea of the same and address of person who are idea of the same and address of person who are idea of the same and address of person who are idea of the same and address of person who are idea of the same and address of the same are idea of the same and address of the same are idea of the sam	completed cause of death (Ite	1684 V	illage Gree	en, Croft	on, MD 2111	4	

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Physici /Medic Examir		al	Decedent's Name (First, Middle, Las. Andra C. Borror Andra Institution, give 2159 Reed Road	4b. City, Town,	or Location of Dea	2. Date of Death Month December	Day 31, 2	2004 ny of Deeth	3. Time of Death 11:25 AM				
	neral ector	Months Days Hours Min. (M							Year)	9. Birthp	olace (State or Foreign htry) bama		
ind 21215-50036 be filed within 72 hours after death with the Maryland I Hyglene.	Department of Health and Mental Hygiene. Important: If item 27s or 28a-f show any injury or other traumatic svent, the Medical Exeminer must be notified at once.	Completed by Funeral Director	10a. State 10b. County 10c. City, Town or L				ville			Citizen o	f What Cour	0d. Inside City Limits 1 ☐ Yes 2 No	
leath with			2159 Reed Road				21758 Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				USA		
Ours after d			1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 17\No			f Yes, specify Cul		rto Rican, etc.)	n, etc.) Black, White, etc. Specify: White			
TZTD-U			(Specify only highest grade completed) (Give kind of ville. DO NOT					d of work done during most of working NOT use retired)			Kind of Business/Industry		
Baltimore, Maryland 21215-0035 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Marial Hyglens.		To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First,							•			
ind 2 should hard N		-	19a. Informant's Name/Relationship (Type, Print) Christine Jones/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2159 Reed Road Knoxville, MD 21758										
Pages 1 a			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I 1 ☐ Marial 5 ☐ Other (Specify,		20b. P	Place of Dispo- emetery, cren	sition (Name of natory or other pla	ace)	Date 2	oc. Location	- City or To	wn, State	
Demit.	Daitimole, III 21201									Baltin	more S	treet	
Physi /Med Exan	dical		23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a						ac or respiratory arres	t,		Approximate Interval Between Onset and Death Uncountly	
	death. stor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit	cal Examiner	Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Covenary Artery Disease Due to (or as a consequence of): Due to (or as a consequence of):								years	
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al Meco n: The lawre								1 ☐ Yes 2	topsy prior to completion of cause of death? 2 ▼No 1 □ Yes 2 ▼No				
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he Hospi in 24 hour												ated. the cause(s)	
Tot	200	2	29b. Signature and title of certifier Decrease 44		29c. License number 29d. Date signed (Month, Day, Year) 347682 January 9, 2005 Print) Print) Printy Spring Read, Olney, Mary land, 20832				Day, Year)				
			30. Name and address of person who c Bennett Murring	ompleted cause of d	leath (Item	- Scend	y Spring	Read, O	Iney, mar	1 and	1, 208	12	
ng R	Sta legistra		JAN 1 4 2005	32. Registr	ar's Signa	Hosele							

		ricate of Death	Reg. No.							
Physician	Decedent's Name (First, Middle, Last) Brodis W. Cherry	2. Date of Death Month Day Year DECEMBER 31, 2004 2:41								
/Medical Examiner		J L DECE 4b. City, Town, or Location of Death	MBER 31, 2004 2:41 P M							
Examiner	5453 NEWTON AVE # 4	HYATTSVILLE	PRINCE GEORGES CO							
Funeral	The second secon	If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month)	Birth 9. Birthplace (State or Foreign Country)							
Director	217-78-9875 15 M 2 F 41 Yrs. Usual Residence of Decedent	10-	-5-1963 Va							
ow ow	10a. State 10b. County 10c. City, Town or Local	ition	10d. Inside City Limits							
the Marylan r28e-f show the control of the control	Md Prince Georges Hyattsvil	1e	1 ☐ Yes 2 🛣 No							
vith the Mar or 286-1 s	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?							
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by b	Maynte me youll my	OCME	JANUARY 1, 2005							
39. Name and addless of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MAF										
State Registrar	31. Date filed (Month, Day, Year) JAN 1 9 2015 32. Registrar's Signature									
DHMH 17 Rev 1/2001	JAN 1 9 2005 Allegens 15	Med								

				State of Ma	aryland		rtment of l			lental Hy	giene 2 (04	42933
			1. Decedent's Name (First, Middle, Last)						2. Date of De	eath		3. Time of Death
	Physici /Media		Ruth FI	anders						Month / 2	Day 2 7	Year	755 pm
	Examir		4a. Facility Name (If not institution, give	•						cation of Deat	h 4c. County	of Death	
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ı	Funeral		5. Social Security Number 6. Second 10 10 10 10	714 0177 =	e (In yrs. Ia: 00	st birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bir (Month, Da	orth ay, Year) 0. 1904	9. Birthplac	e (State or Foreign Naryland
	Director		212-50-4475 Usual Residence of Decedent		00	113.		1		July 3	0, 1904	Λ	narykana
	/land		10a, State 10b. County		10c. City,	Town or Loc	ation					10d.	Inside City Limits
	Many a-f sh	į	Jersey Uni	on			Cla	vrk					1XXYes 2 □ No
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	r dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U,S.	. 13. W	as Decedent of I Yes, specify Cub	lispanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)	- 14. Rad Bla	ce - American ck, White, etc	
20	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28e-f show that the Medical Examiner must be multified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give	lo		□Yes 200 No				Specif		
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<u> a</u>	vid by Menta	2	Richard Oliver Ho	erbert					Mary	Grace	Hayden		
Maryland 21215-0020	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health end Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mcdical Examiner manal by rediffied at	·	19a. Informant's Name/Relationship (Ty	•		19b. Mailing	Address (Street	and Numbe	er or Rura	l Route Numb	er, City or Town,	State, Zip Co	ode)
≥	and ealth n 27 ner tr		Grace E. Driesens	(Sister)	100				Clar		Jersey		
9	ges 1 a t of Hea if item or othe		20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 □ R	emoval from State		-	tion (Name of atory or other pla	ce)		Date	20c. Location		
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j.	the d y the achec	lys!	Part II. Other significant conditions con	tributing to death bu	t not resulti	ng in the und	erlying cause giv	en in Part I.		23b. Did 1			e cause of death?
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cords,	v requires that the de been signed by the s should be detached	8 9								24a. Was	an autopsy	24b. Were	autopsy findings ole prior to
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ř	sician: The law certificate has birector, page 2 s	Completed								101	Yes No	1 □ Ye	es 2□ No
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- -	Physician: rthls certific rral director,	၉	1 ☐ Yes > No	ospital: 1 🗆 Inpatier	nt 2 EF	NOutpatient	3□ DOA Oth	4 PU NU	rsing Hon	ne 5 🗆 Resid	dence 6 □Oth	er (Specify)	
_	ding Pl h. After ti funera	ë	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28	Bb. Time of Injury	28c. Injur Wor			8d. Describe h	now injury occuri	red	
<u>s</u>	Attendi er death ector: A by the f	cat	2 Accident investigation 3 Suicide 6 Could not be	One Diese of Iniv	At h			Yes 2□!		Inf Location /	Street and Numb	or or Pumi Pr	oute Number
DIVISION	of or Attending F setter death. I Director: After in by the funer.	Certification:	4 ☐ Homicide determined	28e. Place of Inju building, etc.	(Specify)	e, iaiii, siree	it, factory, office		-	City or Tox	vn, State)	er or nararno	oute Number,
	spital	a C	29a. Certifier Certifying Phys	ician: To the best of	my knowle	edge, death o	ccurred at the tir	ne, date and	d place, a	nd due to the	ceuse(s) and ma	inner as state	d.
	To the Hospital or J within 24 hours efter To the Funeral Dire completely filled in b	edical	(Check only 2 Medical Exeminone)	er: On the basis of and manner stat	examination	n and/or inve	stigation, in my o	pinion, deat	th occurre	ed at the time,	date and place,	and due to the	cause(s)
	To the comp	ž	29b. Signature and title of certifier	1/			29c. Licens				29d. Date signe	d (Month, Day	, Year)
	p e Ar		NIX X	Clean	w	رفرد	1) 4	1338	16		1.11.	05	
_			30. Name and eddress of person who co										
1	Ø		Daniel R.	1.tower	راه (۱۳۰۶)	1714	Ei tow	Place	*	Baltic	rore v	40 2	1217
	Sta Registr		JAN 1 3 2005	32. Registra	Signatur	book				•			

			State of Maryland / Department of I 1 - Registrar Certificate of		ygiene2004	42934
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) MARGARET ELIZABETH GONCE 4a. Facility Name (If not institution, give street and number) 4b. City, Town,	2. Date of Death	Death Day Year 23 2004 4c. County of Deat	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 AF 7. Age (In yrs. last birthday) If Under 1 Year Months Days	WSon, Md. 2/2 If Under 24 Hrs. 8. Date of B Hours Min. (Month, I	Birth 9. Birth Day, Year) Co	more Cor thplace (State or Foreign sunity) yland
	ne Maryland 8e-f show	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD BALT. Co. TOWSON			10d. Inside City Limits 1 ☐ Yes 2√ No
ဖွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if Item 27 is marked other then "naturel", or Items 23e or 28e-f show any injury or other treumatic event, the Madical Exattainst must be notified at ODGs.	Funeral Director	10e. Street and Number 8	Hispanic Origin? (Specify Yes or Noban, Mexican, Puerto Rican, etc.)	10g. Citizen of What Co	orican Indian, e, etc.
21215-0036	within 72 hours iene. then "naturel", the Modical Exa	Completed by	3 ■ Widowed 4 □ Divorced Year or Dates:	ipation a during most of working ad)	16b. Kind of Business/	Andustry
Maryland 2	nould be fited a Mental Hyg narked other natic event,	To Be C	William Spehnkouch	18. Mother's Name (First, Middle Margaret	Euler	Zin Code)
ore, Maı	jes 1 and 2 st of Health and of Item 27 Is n or other treun			idand Number or Rural Route Num idge Loop Cockey Date Date		21030
Baltimore,	permit. Pag Department Importent: any injury once.		*4 Donation 5 Other (Specify) 21. Signature of Funeral Sprace Licensee And Address Wades it ector State And Address Baltimore	¦ ሮቼሐቻ ^{ac} ቼbard 655 W , MD 21201	. Baltimore	Street
	Physician /Medical		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dy shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Direct (or as a consequence of):	ing, such as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
8760,	ate be executed by sician and he burial-transit	licai Examiner				<i>U</i>
P.O. Box 68	death certifi e attending I od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ Unknown	эу	23d. Date of del Month	ivery Day Year
	law requires that the de as been signed by the a 2 should be detached				tobacco use contribute to	o the cause of death?
tal Reco	The larate has	e Completed by		24a. Wa aut per 1 Yes	formed? prior to death?	utopsy findings available completion of cause of
Division of Vital Records,	ing Phys n. After this funeral di	ToB	examiner? 1 Yes 2 No	ther: 4 Nursing Home 5 Re	1/	-
Divisi	oitel or Attendi urs after death, orel Director: A	Certification:		City or T	(Street and Number or Ruown, State)	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	29h. Signature and title of certifier 29c. Licen	opinion, death occurred at the time	e, date and place, and due	h, Day, Year)
)			30. Name and address of person who completed cruse if death (Item 23a) (Type, Print)	30433 ARUT SI :	JAN, OB,	MU
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	j. 100 / 01		0207

ORIGINAL

			1 - For Amend Ite State Registrar	ems 23a per	of Ma	arylan G	d/Depa 339,01	rtment of H	eaith and l	Mental Hy	giene	04	42935
			1. Decedent's Name (First, A			-				2. Date of D		Year	3. Time of Death
	Physic /Med		Chloie D. Hu							Decem	ber 22	,2004	450 PM
	Exami	ner	4a. Facility Name (If not instit	111 R.	number)			4b. City, Town, or	Location of Death	1	4c. Courl	ty of Death	}
	Funeral		Mariher Ha 5. Social Security Number	6. Sex	7. Ag	e (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.		rth	9. Birthp	place (State or Foreign
	Director		578-34-7085	1□ M 2√QF		85	Yrs.	Months Days	Hours Min.	Dec. 4	, 1919_	Penn	sylvania
	and w		Usual Residence of Deceder 10a. State 10b. Co			10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	Maryl -f sho	ō	Md. H	arford			Be1	Air					1 ☐ Yes 2 ☑ No
	h the or 28e	Director	10e. Street and Number			1		10f. Zip Code			10g. Cîtizen o	What Cour	ntry?
	ath wil	rai	1831 Still P						015		U.S		
	er det	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐		Forces?		S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	0- 14. Ra	ace - Americ ack, White,	
	Urs aff	by	3 ☐Widowed 4 ☐ Divo	If Vas	Give r Dates:	.40		1 ☐ Yes 2 ☐xNo	Specify:		Spec	ity: whi	te
	5-0 72 ho	Completed		edent's Education ighest grade complete	nd)		(Give	dent's Usual Occupa	furing most of wor	king	16b. Kind of	Business/In-	dustry
	within me.	mpi	Elementary/Secondary (0-		e (1-4or 5	5+)	life. I	DO NOT use retired)		fodo	x a 1 a	arra rn man t
	d 2 filed v Hygie other i	ပိ	12 years 17. Father's Name (First, Mid	idle, Last)			sec	retary	18. Mother's Nan	ne (First, Middle			overnment
	land be dental riked of	To Be	Winfred Wils	on					Rena	Carr			
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or hems 23a or 28e-f show any injury or other treumatic event, the Modical Econometric must be notified at any once.		19a. Informant's Name/Rela Pamela Hudso	1				ng Address <i>(Street a</i>			. ,		Code)
	os 1 ac of Hear Item		20a. Method of Disposition 1 Burial 2 Cremat	0 D D	C1-1-	20b. P	lace of Dispo	sition (Name of natory or other place	θ)	Date	20c. Location	- City or To	own, State
	Page ment tent; if		'4 □Donation 5 □Oth		JIII State	Ga		Heaven Ce		7/2004	Silver	Spri	ng, Md.
	Ball permit Depart Import any in		21. Signature of Funeral Ser	vice Licensee			S	Name and Address chimunek 10 W. Mac	Funeral				
	Physician		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final	List only one cause o	at caused n each lin	ne.	n. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a		a conseq	uence of):			Delicit.	La		VICTORIA S
~	Examiner	-	Secuentially list conditions,	b. —	io tor as	a consequ	uence po:						
3	uted d ansit	Examiner	S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	*	(0. 45		201100 017						
2	8760, at the best of the second and the burial-transit		resulting in death) Last	Due Due	to (or as	a consequ	uence of):						
	8760, sate be enthe shysician	dicai		d									
	Box 687 leath certificate attending phys for use as the	/Me	IF FEMALE:	23c. If yes,	outcome	of pregna	ncy				23d D	ate of delive	any
	ath ath	Physician/Medical	23b. Was decedent pregnan in the past 12 months? 1 Yes 2 No	1 ☐Liv 4 ☐ Pre	e birth egnant at	2 Fetal	death 3	Ectopic pregnancy Other (specify)				lonth	Day Year
J	of the ache	hys	9 🗆 Unknown	9□ Un	known								
	Records, P he law requires that e has been signed t	by	Part II. Other significant cor	nditions contributing to	o death b	ut not resi	ulting in the ur	nderlying cause give	en in Part I.	23e. Did	4		ne cause of death? ably · 4 □Unknown
4	law rec	Completed								24a. Was		Were auto	psy findings available inpletion of cause of
		E O								perfe 1 🗆 Yes	ormed? 2 No	death?	
-	of Vital Re Physicien: The lav this certificate has	Be	25. Was case referred to me examiner?	Hospital				Othe	26. Place of Dea				
<	on of V	5	1 Yes 2 No	1	Inpatie		ER/Outpatien 28b. Time of		4 Alvursing H	ome 5 Res	dence 6 Other		1)
152	On Iding Ith. After	ation	1 XNatural 5 □ Pe	ending (M vestigation	te of Injui Ionth, Daj	ý Year)	Injury	28c. Injury Work M 1 []	(? Yes 2 □ No				
4udson	Division of Vital or Attending Physicien: T after death. Director: After this certificat. In by the funeral director, ps	Certification:	3 ☐ Suicide 6 ☐ Co	ould not be stermined 28e. Pla	ace of Injuding, etc	ury - At ho c. (Specify	ome, farm, str	eet, factory, office		28f. Location (City or To		ber or Rura	l Route Number,
	Division of To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	edicai C	29a. Certifier 1 Cer (Check only 2 Med one)	tifying Physician: To lical Examiner: On the and m	the best of basis of anner sta	f examina	wledge, death tion and/or inv	occurred at the time time of the stigation, in my of	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and m date and place	anner as st	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of ce					29c. License			29d. Date sign		
	15		•	- Top		MD			5660	/	Decimi	sir 2	2nd 2004
	10			1ELD, 60	25.	17 Tu	JOED K		5 BEI	LAIR	MD	210	014.
1	St Regist	ate rar	31. Date filed (Month, Day,)			ar's Signa	hall	,					

			1 - For State Registrar	State of M	laryland /		rtment of I	Health and I Death	Mental Hy	giene Reg. No. 1	1 1293	6
	Physici		Decedent's Name (First, M Lillie Mae						2. Date of De Month Dec.	Day 24, 200	3. Time of Deat Year 1:03 P	M
	/Medic Examin		4a. Facility Name (If not institu				4b. City, Town,	or Location of Death		4c. County		
	F		Civista M 5. Social Security Number	edical Cent	er ge (In yrs. last b	irthday)	La P1		8. Date of Bir	Char		
	Funeral Director		422-58-9452	1 □ M 2 /□ Æ	60	Yrs.	Months Days	Hours Min.	Jan. 9	, 1944	Birthplace (State or Fore Country) AL.	argr i
-	A.		Usual Residence of Deceden 10a. State 10b. Cou		10c. City, Tov	wn or Loc	ation				10d. Inside City Lim	nite
S	ith the Marylen or 28a-1 show	ctor		ıval				onville			Mode on y Em	
Hawkins	23a	ral Director	10e. Street and Number 1449 W. 24	1th Street			10f. Zip Code	2209		10g. Citizen of W	/hat Country? SA	
N/	items	nue	11. Marital Status 1 □ Never Married 2 □ I	12. Was Deceden Armed Forces	?	13. V	as Decedent of Yes, specify Cub	Hispanic Origin? (S oan, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race Blace	e - American Indian, k, White, etc.	
36	within 72 hours after ene. then "natural", or Ite ne Medical Evaruhe	Completed by Funeral	3 Widowed 4 N Divor	If Yes Give	_	1	☐ Yes 2 No	Specify:		Specify:	Black	
_ u)	"natur	eted	15. Dece (Specify only hi	dent's Education ghest grade completed)	16a	(Give I	ent's Usual Occu and of work done O NOT use retire	during most of wor	king	16b. Kind of Bu	siness/Industry	
2121	filed withir Hygiene. other than ent, the Ms	dmo	Elementary/Secondary (0-1 12	2) College (1-4or	5+)	me. L	Custo			Danny C	leaning	
nd ;	al Hygie I other ivent,	BeC	17. Father's Name (First, Mide	dle, Last)				18. Mother's Nan		, Maiden Surname		
//	2 should be and Mental is marked o	2	Willie Jam						Ruth R			
Mar	s 1 and 2 should be file f Health and Mental Hyg item 27 is marked othe other treumatic event,	1 %	19a. Informant's Name/Relati	enita Hawkins				ham Point			State, Zip Code) MD 20643	
ore,	of Health of Health item 27 I		20a. Method of Disposition		20b. Place o	of Dispos	ition (Name of atory or other pla	ace)	Date		City or Town, State	
, Baltimore,	Page tment tent: If jury or	1	4 ☐ Donation 5 ☐ Othe		' Spring	g Hil	1 Cemetery	7 12/30/		Perr	y FL	
Bal	permit. Pages 'Department of H Importent: If ite eny Injury or ot once.	1 10	21. Signature of Funeral Serv	rice Licensee Victor P	Doda, Ji	<u> </u>	Name and Addr Parles L. S Ol Fast Fo	ess of Facility Stevens Fund ort Avenue,	eral Home, Baltimore	Inc. MD 21230		
			23a. Part1. Enter the disease shock, or heart failure.	e, or complications that cause List only one cause on each	ed the death. Do line.						Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 150	hem. c		Heart	Disea	¿ Se		Onset and Death	
	Examiner		-	Due to (or as	s a consequence	of):						
13	D ::	iner	Sequentially list conditions, it is a last in the clute cause. Enter Underlying Cause (Disease or injury	Due to to as	s a consequence	of):						
A , I.	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	s a consequence	of):		_				
8760,	ate be executed hysicien and the burial-transit	dicai E		d								
89	antifica ling ph e as th	Med	IF FEMALE:									
Box 6	eath certific attending p	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	I LILIVE DITE	e of pregnancy 2 Fetal death at time of death		Ectopic pregnanc Other (specify)	;y		23d. Date Mon	of delivery th Day Year	
0.	that the de ed by the detached	hysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	it time of doubt	50	Other (specify)					
JS, F	ires tha signed i be det		Part II. Other significant con-	ditions contributing to death	but not resulting i	in the un	derlying cause gi	ven in Part I.			bute to the cause of death? 3 ☑ Probably 4 □Unknow	wa
corc	w requires been sign should be	letec							24a. Was			
Re	The lay	Completed			-				autor	psy pr rmed? de	/ere autopsy findings availal rior to completion of cause d eath? □ Yes 2 ≥ No	of
/ital	ysician: Th	BeC	25. Was case referred to med examiner?					26. Place of Dea			163 24340	
of	Physic this c	2	1t Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpati		utpatient Time of	3 L DOA			dence 6 Other		_
ion	nding Ph tth. r: After th e funeral	ation	1 SNatural 5 ☐ Per	nding 28a. Date of Inj (Month, Date of Inj (Month, Date of Inj (Month, Date of Inj	ay Year)	Injury	28c. Inju Wo M 1	rk?]Yes 2 □No	200. 00301100 1	iow injury occurre	o .	
Division of Vital Records, P.O.	ul or Attending Physician: The law requires that the death certific atlant death. I Director: After this certificate has been signed by the attending p of in by the funeral director, page 2 should be detached for use as	Certification;		uld not be ermined 28e. Place of In building, e	ijury - At home, fa tc. <i>(Specify)</i>	arm, stre	et, factory, office		28f. Location (S City or Tox	Street and Numbe vn, State)	r or Rural Route Number,	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier 1 Certi	fying Physician: To the best	of my knowledg	e, death	occurred at the ti	me, date and place,	and due to the	cause(s) and man	ner as stated.	
	the H hin 24 the Fi	Medical	one)	cal Examiner: On the basis of and manner si	tated.	navor invi						
	o T wit	-	29b. Signature and title of cer	M. TAyouni			29c. Licens				(Month, Day, Year)	
	6		30. Name and address of pers	son who completed cause of	death (Item 23a)	(Type, F		50883		DEC. CS	. 2001)	
	9		Yahia Tagou	ri,MD 25500	Point	Lo	okout I	Road Leo	nardto	wn. Mar	yland 2065	<u>.</u>
	Sta Registr		JAN 1 4	2005 Alexandria	rar's Signature	book					_	

			_ For	State of		nd / Depa	artme	nt of H	ealth a		ental Hyg		_	42937
			1 - State Registrar			Cei	rtifica	te of L	Death			leg. No.	-00-	
	Physici	an	1. Decedent's Name (First, Middle, La								Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic		Judith C. Ios								Decembe			
	Examin	er	4a. Fecility Name (If not institution, gi		oer)				Location of				County of Dea	
			632 Severn Ro 5. Social Security Number 6.		Ane /In vrs	last birthday)		er i Year	na Par		8. Date of Birth	h	nne Ar	
	Funeral Director			1 □ M 2 🂢 F	57		Month		Hours	Min.	Month, Day Mar 18,	/, Year)		rthplace (State or Foreign ountry)
	4		Usual Residence of Decedent						L		iai io,	134	·/ Ma	ryland
	ylan how		10a. State 10b. County MD Anne Art	ında 1	10c. Ci	ty, Town or Lo		. 1						10d. Inside City Limits
	a-f.	cto	Affile Art	ilide I		Sever	na F	ark						1 ☐ Yes 2 No
	be filed within 72 hours after death with the Maryland and hylysene. All the Westernal, or Items 28a or 28a-f show do then than "natural", or Items 28a or 28a-f show event, the Medical Examinar moral be notified at	Director	10e. Street and Number				10f. 2	ip Code				10g. Citi	zen of What C	ountry?
	23a		632 Severn Road						1146				USA	
	r der	Funeral	11. Marital Status	12. Was Deced Armed Forc	es?	J.S. 13.	Was Dec	edent of Hi ecify Cuba	ispanic Orig n, Mexican,	gin? (Spe i, Puerto l	cify Yes or No- Rican, etc.)		 Race - Am Black, Whi 	
36	s afte	by Fi	1 ☐ Never Mamed 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2			1 🗆 Yes	2 X No	Specify:				Specify: T	white
Ö	hour tural	p p	15. Decedent's E	Year or Date	9S:	16a Dece	dent's He	ual Occup	ation			16h Kir	nd of Business	
<u>.</u>	in 72 " na ledic	Completed	(Specify only highest gi	rade completed)		16a. Deced (Give	kind of v	vork done d use retired	during most	t of workir	ng	100.10	id of business	sindustry
212	with iene.	mo	Elementary/Secondary (0-12)	College (1-4	or 5+)			ate a					propert	ties
ğ	i Hyg t Hyg othe	Be C	17. Father's Name (First, Middle, Las	t)						r's Name	(First, Middle,			unk
a	should be ad Mentat marked o	To B	James B. Dunku	m										
Maryland 21215-0036	should land Mania market		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Addre	ss (Street a	and Numbe	r or Rura	Route Numbe	r, City o	Town, State,	Zip Code)
Σ.	and salth		David Iosbaker/	spouse		632	Seve	rn Ro	ad Se	vern	a Park,	MD	21146	
ore	of Ho of Ho of oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from St		Place of Dispo cemetery, crer	sition (Natory o	ame of other plac	e)	D	ate	20c. Lo	cation - City or	Town, State
Ē	Pag ment ant: lury o		* 4 X Donation 5 □ Other (Spec	ity) 1										
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic e- once.		21. Sgnatt of Funeral Selvice Lice S	1/11/	ecto	r St	tate	Anato	omy Bo MD	oard	655 W.	Ba1	timore	Street
h	- 15		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that cau	sed the dea	th. Do not ent	er the m	ode of dyin	g, such as	cardiac o	r respiratory ari	rest.		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			ce								Onset and Death
	/Medical		resulting in death)		as a consec				WIC C					gras
Ы	Examiner		Sequentially list conditions,	b										
	ps is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consec	quence of).								
	and and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or	as a consec	suence of):								
60,	ate be executed iysician and he burial-transit	calE		200 (0)	40 4 00.750	,400.100 0.7.								
687	phys phys s the	_		d										
	leath certificate attending phy I for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregn	ancy						1 2	3d. Date of de	alivery
Box	leath atter	clar	in the past 12 months? 1 ☐ Yes 2 ☑ No		h 2 ∏Feta at at time of c		Ectopic Other	pregnancy specify)					Month	Day Year
o.	the cy the	Physician/Med	9 Unknown	9□ Unknow	m									
ري. ت	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by P	Part II. Other significant conditions	contributing to dea	th but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco u	se contribute t	o the cause of death?
Records,	quire an sig uld b	edt									1 🗆 Y	es 20	2No 3□P	robably 4 Unknown
000	aw re	plet									24a. Was a	an	24b. Were a	utopsy findings available completion of cause of
	The lav	Completed									perfor	med?	death?	s 2 No
Viital		Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or			
	hysic his ce I dire	To	1 Yes 2 No	Hospital: 1 🗆 Ing	patient 2]ER/Outpatien	nt 3□ I	Othe Othe	er: 4 🗆 Nur	rsing Hon	ne 5 Thesid	ence 6	Other (Spe	ecify)
0	ng Pl		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		28c. Injury Work	al c?	2	28d. Describe h	ow injury	occurred	
Sio	utending Physideath. ctor: After this of the funeral dir	catl	2 Accident investigation 3 Suicide 6 Could not	ho -			М		Yes 2 N					
Division of	or Ati	Certification:	4 Homicide determine	288. Place 0	f Injury - At h , etc. <i>(Speci</i>	iome, farm, str fy)	eet, fact	ory, office		2	28f. Location (S City or Tow			'ural Route Number,
_	To the Hospital or Attending Physicien: which 24 hours alter deals as a feet this certific to the Funeral Director. After this certific completely filled in by the funeral director,			hysician: To the b										
	the H hin 24 the F nplete	Medical	one)	and manne	r stated.	and and or in								
)	Witl To	4	29b. Signature and title of certifier	/				9c. License	000			t	signed (Mon	
			in Moder					レベス	782	<u> </u>	V	anc	1ay 11,	2005
			30. Name and address of person who	completed cause	of death (Ite	1)	Print)	Ynest	12.	/XI	11 / D	10.	1. 1.	2005
	Sta	te	31. Date filed (Month, Day, Year)	32. Rec	iştrar's Sign	ature	A. 1	NAGEL	4 7 GY	1 I'M	JOM , //	ery 1	and -	1200
West .	Registr		JAN 1 9	2005	1. 18.08.2451	Dr. J	Some	"						

			1 - For State Registrar	State of Ma	ryland	i / Depa <i>Cer</i>	artment of H tificate of I	lealth ar D <i>eath</i>	nd Mer	ntal Hyg	giene Reg. No.	004	42938
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) Paul		endaa	1			D	Date of Dea Month	Day	Yea 2004	1 5:00 AM M
Ì	Examin	er	4a. Facility Name (If not institution, give si Genesis Layhill 5. Social Security Number 6. Sex	Center	(In vrs. la	st birthday)	4b. City, Town, or Silve	Location of I er Spri	ing	Date of Birth			gomery'
	Funeral Director		219-96-8714 ¹ Usual Residence of Decedent	M 2□F	81	Yrs.	Months Days		Min. No	Date of Birth (Month, Day V • 4 •	192		lirthplace (State or Foreign Country) (aryland
	ne Marylar 8a-f ehow	Director	Maryland Montgom	ery	10c. City,	Town or Lo	Rockv	ille					10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 2	ai Dire	10e. Street and Number 4227 Landgreen St	•			10f. Zip Code	20853				on of What of United	Country? I States
036	hours efter death with the Maryland turel', or Iteme 23e or 28e-f ehow at Examiner must be notified at	by Funerai	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☒ No	ispanic Origin n, Mexican, F Specify:	n? (Specify Puerto Rica	Yes or No- an, etc.)		Black, Wi	merican Indian, nite, etc. White
Maryland 21215-0036	I be filed within 72 hours efter death with the Marylan ntal Hygiene. ed other than "natural; or liteme 23a or 28a-f show event, the Maritical Examinet must be natified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5-	+)	(Give life. L	dent's Usual Occupi kind of work done of DO NDT use retired ever Worke	during most o l)	of working		16b. Kir	nd of Busines	·
land	2 should be filed and Mental Hyg is marked other reumatic event,	To Be C	17. Father's Name (First, Middle, Last) (Unavailable)					18. Mother's (Una	s Name <i>(Fi</i> Va il a		Maiden :	Surname)	
, Mary	permit. Pages 1 and 2 should be Deperment of Health and Menta Importent: If Item 27 is marked any Injury or other treumatic e <u>once</u> .		19a. Informant's Name/Relationship (Type Annise Chapmon / S			401	g Address (Street a Hungarfo	rd Lan					, <i>Zip Code)</i> 1852
Baitimore,	Pages 1: ent of He nt: if iten ry or oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re `4 □ Donation → □ Other (Specify)	emoval from State			sition (Name of hatory or other plac ce Cremate		Date 12/11				or Town, State
Balti	permit. Depertm Importe any Inju		21. Signature of Funeral Service License	460	Cars	22 R	Name and Address Rapp Fune:	ss of Facility	d Cre	matio	n Se	rvices	3
ľ	Physician		23a Part f. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each lin	е.		er the mode of dyin						Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	•		dation						
	uted d anslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a		ence of): f Hear	ing						
8760,	cate be executed physician end the burial-transit	dicai Ex	resulting in death) Last	Due to (or as a			ndylosis						
O. Box 6	ath certifi attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 ☐ Fetal o	death 3□	Ectopic pregnancy Other (specify)				2	3d. Date of d Month	lelivery Day Year
rds, P.	w requires that the de been signed by the a should be detached to	by	Part II. Other significant conditions conf	ributing to death bu	it not result	ting in the ur	nderlying cause give	en in Part I.					to the cause of death? Probably 4 XUnknown
II Records,		Completed			_					24a. Was a autops perform	sv		
Vital	sicien: s certific lirector,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatier	nt 2∏E	R/Outnation	t 3 DOA Othe	0.0		heck only or		Other (Sp	nacify)
Division of	or Attending Physicien: siter death. Director: After this certific in by the funeral director.	ation; T	27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	у 2	28b. Time of Injury	28c. Injun Work	/ at	28d.	. Describe h			Journ
DIVIS	To the Hospitel or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc			eet, factory, office		28f.	Location (S City or Town		Number or i	Rural Route Number,
	Ne Hospi	ledicai	29a. Certifier (Check only one) 1 X Certifying Phys 2 Medical Examin		examination								
	To the within To the comp	Me	29b. Signature and title of certifier Www.sice /	hilling	P , ~	~.0.	29c. License D5	number 6691		2			er 8 , 2004
			30. Name and address of person who cor Ghousia Sultana	npleted cause of de			•	Cir.;	Silve	er Spr	ing,	MD 20	0906
	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 9 2005	32. Registra							_		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 31, 2004 1:30 AM **Physician** Laura Latta /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Glen Burnie Anne Arundel Millenium Marley Neck If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Months 1 □ M 2 🖾 F Yrs Virginia July 1, 1910 94 215-40-7428 Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene. other then "netural", or items 23e or 28e-f ehow 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or Items 23e or 28e-f ehow any Injury or other treumatic event, the Maddal Examine. Imat be notified at 1 ☐ Yes 2 No Glen Burnie MD Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 21061 7575 E. Howard Street USA Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married white 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) housewife unk own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Noah Webb Edina Mundie 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 132 Shellcove Road Pasadena, MD William Latta/son 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Ronald S. Wader State Anatomy Board 655 W. Baltimore Street TOUS Baltimore, MD 21201 23a. Peli 1. Enter the disease, or complications it is caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirts, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of): Examiner ettending physicien end I for use as the bunel-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) signed by the et t be deteched fo 23b. Did tobecco use contribute to the ceuse of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 24b. Were autopsy findings available prior to page 2 should t 24a. Was an autopsy performed? elebrovasciela accirent Completed completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 1 🗆 Yes this certificete I or Attending Physicien: after death. Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: t ⊠Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital o within 24 hours aft To the Funeral DI completely filled in 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Hedical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie 29c. License number 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) HOPRA MD 600 Ridge 10 Aug. Stc. 23) Annapolis, mo-21407 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Gosta Registrar

DHMH 16 Rev 6/95

thony Luther Jr. Amend Item I per me G840 2-17-05 tas
State of Maryland / Department of Health and Mental Hygiene -8467 42940 1- State Unpend Item 23a&27 per me G839 entite at 5 of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Luther Anthony Jr. . Day 31, Physician 2004 Jr. Luther December 1000 a /Medical 4a. Facility Name (If not institution, give street and number)
1103 Appleton Street 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08 05 57 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral X X** 4 2 □ F Yrs. 216-68-4419 Director 47 MD Usual Residence of Decedent Maryland 10b. Count 10c. City, Town or Location 10d. Inside City Limits 10a. State r then "naturel", or Items 23e or 28e-f ehow the Medical Evantiner must be notified at 1 Yes 2 No Baltimore MD NA Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1103 North Appleton Street 21217 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married ☐Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Various Jobs 12th grade na Laborer 7 Is marked other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 and 2 should be fil f Health and Mental H item 27 Is marked off Viola Bellamy Luther E. Anthony Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Luther E. Anthony Sr. Father 1103 North Appleton St., Balto, Md 21217 item 27 other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of F. Importent: If ite eny injury or ott 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 □ Donation 5 □ Other (Specify) King Memorial Park 1/7/05 Md Randallstown, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West himpsin 4300 Wabash Ave, Baltimore, Md 21215 rome 23a. Part l Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Pancreatitis and Cirrhosis of the Liver /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any least to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Examine certificate be executed burial-tran Due to (or as a consequence of): 68760 physicien Physician/Medical the Box (IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month ŏ Day Year 4 Pregnant at time of death 5 Other (specify) o the 9 Unknown by ۵. signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? page certificate Yes 2 No Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) t Scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1X Yes 2 No 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division or Attending 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined after 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier npletely (Check only one) within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ပ OCME January 1, 2005 Whirle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KORELL 111 Penn Street, Baltimore MD 21201 MARGARIOS

Registrar

State

31. Date filed (Month, Day, Year)

JAN 1 5 2005

Registrar's Signature

			1- For Amend Items State Registrar Amend It		apland作Det FH,G839,Ce	ertificate of D	galth and Me Death 01/21	ental Hygie ./05dhb _{log.}	ne 004	42941
	Physici	an	Decedent's Name (First, Middle, I	.ast)				2. Date of Death Month	Day Year	3. Time of Death
	/Media		JAGJIVAN			MISTRY			P 005 SS	M 4200
1	Examir	er	4a. Facility Name (If not institution, g	ive street and number)	10	4b. City, Town, or	Location of Death		4c. County of Dea	ath
				opkins Ho	spital	But mov		Date of Blat	n/a	
г	Funeral Director			1⊠M 2□F	ge (fin yrs. last birthda) Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, Ye	ear) C	nthplace (State or Foreigr country)
			219-98-0995 Usual Residence of Decedent		49		<u> </u> <u> </u> E	'eb. 19,	1955 T	anzania
	yland		10a. State 10b. County		10c. City, Town or I	_ocation				10d. Inside City Limits
	B-f st	tor	Maryland Montgo	mery		Silver Sp	ring			1 X Yes 2 □ No
	th the	ire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
	72 hours after death with the Maryland natural', or items 23a or 28a-f show ited Evarul ar must be notified at	Funeral Director	510 Grand Cypres	s Court		20905		U	nited St	ates
	r des	nei	11. Marital Status	12. Was Decedent Armed Forces?)	. Was Decedent of His If Yes, specify Cubar	panic Origin? (Spec	ify Yes or No- ican, etc.)	14. Race - Am	
36	s afte	by Fu	1 Never Married 2 Married	IT YES, GIVE	No	1 ☐ Yes 2 ☑ No	Specify:	,,	Specify:	10, 010.
2-0036	hour tural	d be	3 Widowed 4 Divorced	Year or Dates:	1 40- 8				Asi	an-Indian
<u> </u>	n 72 n "na	Completed	15. Decedent's (Specify only highest)	grade completed)	(Giv	edent's Usual Occupa e <i>kind of work don</i> e de DO NOT use retired)	uring most of working	g 16b). Kind of Business	s/Industry
2121	within lene. than "	E C	Elementary/Secondary (0-12)	College (1-4or	5+)	,				G
D	filed Hygi other	Be C	17. Father's Name (First, Middle, La	st)		elf-Employ	18. Mother's Name		Service (Station
Maryland	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the Me	To B	Mistrv Ma	ganbhai			Mistr	v	Manibe	n
ary	shound N	-	19a. Informant's Name/Relationship		19b. Mai	ling Address (Street a				
	alth a		Dipak Sutaria/Fr	iend	7503	Oyster Ba	y Way Mon	tgomery	Village,	MD 20886
J.	of Health of Health of Health of Item 27 I		20a. Method of Disposition		20b. Place of Disp	position (Name of ematory or other place	Da	ite 200	. Location · City or	r Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Ecarcinal mental be notified at once.		1 Burial 2 Cremation 3			ndel Crema		6/04 0	denton, 1	Marvland
alti	permit. Departr Imports any Inju		21. Signature of Funeral Service Lic	ensee		22. Name and Address Donaldson			omotows	D A
<u> </u>	Dep any		Juanita R.	Thomas P	M00957	1411 Annap	olis Road	Odent	on, Mary	land 21113
ш			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each if	d the death. Do not e	nter the mode of dying	, such as cardiac or	respiratory arrest,		Approximate Interval Between
10	Pnysician	Bonn	Immediate Cause (Final disease or condition	0		atoms (no				Onset and Death
	/Medical		resulting in death)		a consequence of):	TOWN (III	on Claamac	.10)		140045
	Examiner		Sequentially list conditions,		ic Mueloi	d Leukem	MA			6 years
	si ad	iner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dise to (or as	a consequence of):			111		
	and I-tran	Examin	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):		<u> </u>	THE EXAMINE	<u>R</u>	
68760,	icate be executed physician and the burial-transit			000 10 (6) 20	a 30/130420/100 01/,	(MY BONED B	MEDICAL EXAMINE		
387		edicai		d		- FRITE	ICH TON APPRO			
	w requires that the death certif been signed by the attending should be detached for use as		IF FEMALE:	23c. If yes, outcome	of pregnancy	Option	12		22d Data of da	Viscon
Вох	death cert a attending d for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	Day Year
o.	the d y the ached	iysį	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
٦.	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions	s contributing to death b	out not resulting in the	underlying cause give	n in Part I.	23e. Did tobaco	o use contribute t	o the cause of death?
rds	quire n sig uld bu							1 ☐ Yes	2 X No 3□P	robably 4 🗆 Unknown
00	law reas bee	Completed						24a. Was an	24b. Were a	utopsy findings available
Re	sician: The law certificate has t irector, page 2 s	E O						autopsy performed	prior to death?	completion of cause of
of Vital Records,	an: rtifica tor, p	a)	25. Was case referred to medical				26. Place of Death	1 Yes 2 K	No 1 Yes	s 200 No
Ž	> 0 17	To B	examiner?	Hospital: 1 Inpatio	ent 2 ER/Outpatie	Othor			6 TOther (Spe	ecify)
0 6		ü	27. Manner of leath 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ay Year) 28b. Time Injury	of 28c. Injury Work		d. Describe how in		,
Ö	Attending r death. cotor: After oy the fune	atic	2 Accident investigat	tion	, , , , , , , , , , , , , , , , , , , ,		es 2□No			
Division	or Att	Certification;	3 Suicide 6 Could not determine	ad 28e. Place of In	jury - At home, farm, s tc. <i>(Specify)</i>	treet, factory, office	28	f. Location (Street City or Town, St		ural Route Number,
Ω	fospital c	Ce					Ī			
	Hosp 24 hou Fune Fune	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	Physician: To the best aminer: On the basis of	of examination and/or i	th occurred at the time nvestigation, in my opi	e, date and place, ar nion, death occurred	nd due to the cause d at the time, date	e(s) and manner as and place, and dur	s stated. e to the cause(s)
	to the Hospital or Attendi whin 24 hours after death. To the Funeral Director: A completely filled in by the fu	Med	29b. Signature and title of certifier	and manner st	ated.	29c. License			Date signed (Mont	
1	20		Meschli	7 245		p	5-000			
1	701		30. Name and address of person wh		death (Item 23a) (Type		3-000	De	30ember	22,2004
1	J		Catherine Meschlei		Wolfe Stre	•	ore MA	21287		
	Sta	ite	31. Date filed (Month, Day, Year)	2 32. Registi	rar's Signature	CI COMMY	10.C 1010	21001		
	Regist	ar	JAN 1 8 2005	Buch	1. Spare	V				

CPM 04-08331 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. CLYDE MEADOWS For Amend Item 1&Unpend Item 23a,27,28a-1 per me 6839 1-13-05 tas Registrar Certificate of Death UNK 04-415 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Clyde Calvin Meadows, Jr. 12:50 P ^M 25, December 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 110 South Mount Street Baltimore 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, AUG 11 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 51 Yrs. 216-62-4550 PÃ Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 110 South Mount Street 21217 23a USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , or Itams 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No ģ 3 ☐ Widowed 4 Divorced Specify: white "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify onfy highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrician Television permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth-any injury or othar traumatic evant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clyde Calvin Meadows, Sr. Pauline Dorothy Kissenger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Meadows - ex-wife 2840 Huntingdon Avenue, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory Inc 101/03/05 `4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Serviçe Ucenses CAPA, Stephen D. Lohrmann, PA 8717 Green Pastures Drive, Towson, MD 21286 23a. Part—Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final HYPOTHERMIA COMPLICATING CHRONIC DRUG AND ALCOHOL Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ABUSE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to interest cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (cr as a consequence of). Examine -transit that the death certificate be executed and Due to (or as a consequence of) burial-1 Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ţo. in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 1 Yes 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 50 es 2 1 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence MacOther (Specify) SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1XXYes 2□ No 2 After this FOUND th, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: SÜBJECT EXPOSED TO COLD or Attanding FOUND AT 12:46 P 1 Natural 5 Pending after death, Diractor: Af 1 ☐ Yes 2 No ENVIRONMENT Accident 3 Suicide investigation 12-25-04 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number of Rural Route Number City or Town, State) $110\ S$. MOUNT ST . 4 Homicide BALTIMORE, MARYLAND FOUND IN RESIDENCE within 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce O.C.M.E. December 26, 2004 my of death (Item 23a) (Type, Print) LTT Penn Street, Baltimore, Maryland 21201 person who completed cause 30. Name, and address

Registrar

State

31. Date filed (Month

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Cleath Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 4:35 A M **JERRY** MILLER 12 23 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL MARINER HEALTH OF FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1∰M 2□F Months 218-52-1972 54 Director 9/13/1950 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location wous | 10d. Inside City Limits ir than "natural", or itams 23a or 28a-f shorthe Medical Exercities at MD Director Harford Bel Air 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 950B Pentwood Road 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 7 ment of Health and Mental Hygiene. int: If item 27 is marked other than "n. ry or other traumatic access Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elmer J. Miller Dorothy Doffmyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerry J. Miller/Brother 950B Pentwood Road, Bel Air, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or once. Harford Memorial Gardens 12/28/2004 Aberdeen, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of uneral Service Licensee Harkins Funeral Home, Inc., 600 Main St., Delta, PA 17314 Yank. Enter the disease, of complications shock, or heart failure. List only one caus hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Approximate Interval Between Onset and Death Impediate Cause (Final Pulmonas Pnysician 10 years ease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certiticate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical as ettending p tor use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Vegous Stasis Pulmarate 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2**X** No this certificate Division of Vital 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Atter this certification 25. Was case referred to medical Be 26. Place of Death Check on one examiner? 1 ☐ Yes 2 No Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide tilled 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number D35012 December 27, 2004. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. J. KEVIN LYNCH, 615 W. MACPHAIL ROAD, BEL AIR, MD 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 4 2005 Registra ORIGINAL ORIGINAL

	ian	1. Decedent's Name (First, Middle, Tbukunoluwa Opeo	Last)	Maryland / Detem 23a,2				2. Date of Do Month	eath Day	Year	
/Medic		4a. Fecility Name (If not institution,	give street and number	er)	4b. City, To	own, or Loca	ation of Deat	<u>Decemb</u>		2004 County of Dea	4 10513 A
Lxamii	ici	Laurel Regional			Laurel	L					eorge's
uneral irector		216-71-2904	5. Sex 7. 1 ☐ M 2 ☐ F	Age (In yrs. last birtho Yrs	Months [Under 24 Hrs. ours Min.	8. Date of Bi (Month, D NOV 29	rth ay, Year) 20(9. Bi C 0 4 Mai	rthplace (State or Foreig ountry) ryland
groot. The Medical Evantral must be notified at	al Director	Usual Residence of Decedent	e George	10c. City, Town of	10f. Zip C				10g. Citiz	en of What C	10d. Inside City Limit 1 Gyes 2 □ N country?
ural', or Items 2 L'Enaminer mu	d by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force	⊠ No	13. Was Deceder If Yes, specify 1 \(\text{Yes} \) 28	nt of Hispar y Cuban, M	nic Origin? (S lexican, Puerl pecify:	pecify Yes or N o Rican, etc.)	0- 1		
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0 0	To Be	17. Father's Name (First, Middle, La Omobolaji Omotay	o-Benson			1		ne (First, Middle		Битате)	
em 27 ls ther trsu		19a. Informant's Name/Relationshi Omobolaji Omotay 20a. Method of Disposition 1 ≅ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	ro-Benson ,	/father 7	Mailing Address (S 618 East isposition (Name crematory or othe cional Me	Arbo of erplace)	ory Co	ırt, Laı Date	rel,	Maryla	Zip Code) and 20707 r Town, State
Important: If it any injury or o	1	21. Signature of Funeral Service Ci		M00773	22. Name and A Donalds	Address of Son Fu	Facility ineral	Home, I	P.A.		0707-4389
sician ledical		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Sudden								Interval Between
physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Exter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequence of) as a consequence of) as a consequence of)	:	In I	nfancy			£	Onset and Death
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ther this certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Exter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outcon 1 Live birth 4 Pregnan 9 Unknown s contributing to deat Hospital: 1 In Inp. 28a. Date of Inc. 1 See Place of building. Found Physician: To the basis and manner	as a consequence of) as a consequence of)	atient 3 DOA atient 3 DOA the of 28c A M attent occurred at or investigation, in 29c. t	gnancy gnancy 26. Other: 4 Injury at Work? Times office	Part I. Place of Dea Nursing H The state and place In, death occumber	23e. Did 1 24a. Was auto performence of the performance of the perfo	Yes 2 an ppsy ormed? 2 No one) idence 6 how injury (Street and wn, State) Md cause(s) a date and g	and manner a place, and du	Day Year To the cause of death? Probably 4 Unknow Unopy findings availate completion of cause of the cause

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. importent: If item 27 is marked other than "natural, or items 23a or 28e-f ehow amy injury or other treumatic event, the Madical Examinat must be notified at once.

Physician /Medical Examiner

To Be Completed by Funeral Director

29a. Certifier

Please	e Type or Pri	nt in Black I	ndelib	le Ink.	Ensu	ire A	II Copies	Are L	egible.	A CONTRACTOR	
1 - For Amend Item	State of M ns 25,27,28	aryland/De a-f per M	partme	nt of H	ealth a	and M	1ental Hy	giene	001	10	01 =
Decedent's Name (First, Middle, L.)	.ast)						2. Date of De	Reg. No.	UUU	3 Time	of Death
Dixie Pearson							Month JULY	Day 19	Year 2 <i>00</i>	4 6	38 PM
4a. Facility Name (If not institution, g			4b. Cit	y, Town, or	Location of	of Death		4c. C	ounty of Dea	th	
GOOD SAMARITA				SALT							
5. Social Security Number 254-14-8116	Sex 7. Ao 1 M 2 ☐ F	ge (In yrs. last birthda 80 Yrs.	Month	er 1 Year s Days	If Under Hours	Min.	8. Date of Bi (Month, Di July 4	rth ay, Ye <i>ar)</i> • 192		thplace (State ountry)	e or Foreign unk
Usual Residence of Decedent 10a. State 10b. County		10- City T									
MD 105. County		10c. City, Town or	Baltin	nore						10d. Inside	City Limits es 2 No
10e. Street and Number			10f. 2	Zip Code				10g. Citize	n of What C	ountry?	
5009 Frankford					21206			· ·	USA		
11. Marital Status 1 X Never Married 2 ☐ Married	12. Was Decedent Armed Forces: 1 ☐ Yes 2 ☐		3. Was Dec If Yes, sp	edent of Hi becify Cuba	spanic Ori n, Mexicar	gin? (Sp 1, Puerto	ecify Yes or No Rican, etc.)	0- 14	. Race - Am Black, Whi	erican Indian, te, etc.	
3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 X No	Specify:			S	pecify: b]	Lack	
15. Decedent's (Specify only highest of		(G)	cedent's Us ive kind of v e. DO NOT	vork done a	lurina mos	t of work	ing	16b. Kind	of Business	/Industry	
Elementary/Secondary (0-12) unk	College (1-4or	5+)		ab dri							
17. Father's Name (First, Middle, La				unk		er's Name	e (First, Middle			rtation	unk
											unk
19a. Informant's Name/Relationship		19b. Ma	ailing Addre	ss (Street a	in <i>d Numb</i> e	er or Rura	al Route Numb	er, City or T	own, State,	Zip Code)	li li
Brenda West/guar	dian	121	0 Git	tings	Aven	ue E	altimo:	re. M	212	39	
20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control of C		20b. Place of Dis	sposition (N	ame of		- 1	Date			Town, State	
21. Signate of Front Trice Sic	ensee de la company	ector	State State Salti	and Addres Anato nore,	s of Facilit Omy B MD	oard 2120	655 W	. Balt	imore	Stree	t
23a. Park. Enter the disease or co shock, or heart failure. List on	mplications that cause to one cause on each I	d the death. Do not ine.	enter the m	ode of dying	, such as	cardiac (or respiratory a	ırrest,		Approxim Interval B	
Immediate Cause (Final disease or condition	ACUT		AL T	-	06					Onset an	
resulting in death)	a. Due to (or as	a consequence of):	1	MILL	RC		ON APPROVED	1111	/		
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):				Λ	W NED	SA WEDIG			
Cause (Disease or injury that initiated events	· PNEL	HONA				T	ION APPILL				
resulting in death) Last		a consequence of):			- 4						
	d. GRAM	NEGATIO	JE C	DRUP	MIST	15					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic					230	d. Date of de Month	livery Dav	Year
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Part II. Other significant conditions	contributing to death t	out not resulting in the	e underlying	cause give	n in Part I.		23e. Did	tobacco use	contribute to	o the cause o	f death?
	ATOMAS						1 🗆	Yes 2□	No 3□P	robably 4 [Unknown
CHRONIC OBSTR	NOTIVE P	ULMONAL	24 D	ISEA	SE		24a. Was		24b. Were a	utopsy finding	s available
	ORY FAILUR					1	perfo	ormed? 2 🔀 No	death? 1 ☐ Yes	completion of	
25. Was case referred to medical examiner?					26. Place		h (Check only	one)			
1X Yes 2 No	Hospital:				4 LI NU		me 5 Res			ecify)	
27. Manner of Death 1 ≤ Natural 5 ☐ Pending 2	28a. Date of Inju (Month, Da	0001 1	У	28c. Injury Work	at :? ∕es 2 📉		28d. Describe Fall	how injury o	occurred		
3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of In	ZUU4 UNK1 jury - At home, farm, tc. (Specify)	nown' street, facto				28f. Location (Street and I wn, State)	Number or R	ural Route Nu	umber,

Examine attending physician and for use as the burial-transit Be Completed by Physician/Medical signed by the aid be detached for this certificate has ral director, page 2 2 Medical Certification;

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

2

State Registrar 29b. Signature and title of certifier RNoronha MD 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

RES 00

JULY 19

Unknown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROHINI NORONHA
31. Date filed (Month, Pay, Year)
JAN 1 8 2005

A. S601 LOCH RAVEN BOULEVARD, BALTIMORE, MD 21239

Unknown

			For State Registrar	State of Maryla		artment of I rtificate of			giene 2004	42946
	Physici /Medio		1. Decedent's Name (First, Middle, Last	Kaposo					er 31, 2004	
)	Examir		4a. Facility Name (If not institution, give Howard Coult 5. Social Security Number 6. Se	nty General	Hospit s. last birthday)		If Under 24 Hrs.		4c. County of Deat	ird
4 4	Funeral Director			ŽM 2□F 70		Months Days		Oct 1,		hplace (State or Foreign untry) tugal
	Maryland -1 show	tor	10a. State 10b. County Howard	10c. C	Colu	mbia				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	3a or 28s	Il Direc	10e. Street and Number 6200-F Foreland (Garth		10f. Zip Code 210	45		10g. Citizen of What Co Portug	,
036	iges 1 and 2 should be filed within 72 hours atter death with the Maryland not Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-1 show or other treumatic event, the Medical Examinar must be multified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puerl Specity:	pecify Yes or No- o Rican, etc.)		rican Indian, e, etc.
Maryland 21215-0036	d within 72 ho giene. Ir then "natur The Medical.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wor	rking unk	16b. Kind of Business/	
land;	uld be filed Mental Hyg rrked othe	To Be C	17. Father's Name (First, Middle, Last) Jermias Rapo	080		_		me <i>(First, Middl</i> e, et Pimer	Maiden Sumame) ntal	
	nd 2 sho lith and N 27 is ma		19a. Informant's Name/Relationship (7) Fatima Medeiros/c				rand Number or Ru reet Fall		or, City or Town, State, 2 MA 02720	Zip Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 th eny injury or other tre <u>once.</u>		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	Place of Dispo	sition (Name of matory or other pla		Date	20c. Location - City or	Town, State
- Balt	permit. Depart Import eny inj		21. Scanling Funeral Service License d S.	Wades li ect	or Si	Name and Address tate Anata ltimore,	omy Boar	d 655 W. 01	Baltimore	Street
8760,	The law requires that the death certificate be executed X X X W W W W W W W W W W	dicai Examiner	23a. Palv1. Enter the disease, or comp shock or heart failure. List only commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consider. Due to (or as a consider. Due to (or as a consider. Due to (or as a consider.	Cantival equence of):		ng, such as cardiad	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
P.O. Box 6	that the death certifuled by the attending I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnand Other (specify)	у		23d. Date of deli Month	ivery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions or	ntributing to death but not r	esulting in the u	nderlying cause gi	ven in Part I.		obacco use contribute to	
Division of Vital Records,		Completed						24a. Was autop perfor 1 \(\text{Yes} \)	rmed? prior to death?	topsy findings available completion of cause of 2 No
of Vita	Attending Physician: Th r death. sctor: Atter this certificate by the funeral director, pag	n: To Be	27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier	f 28c, Inju	her: 4 □ Nursing H ryat		ne) dence 6 ⊡Other (Spec now injury occurred	sify)
ivision	Mospitel or Attending is 24 hours after death. 5 Funerel Director: After etely filled in by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str		Yes 2 No	28f. Location (S City or Tow	Street and Number or Ru vn, State)	ıral Route Number,
<u>α</u>	To the Hospitel or Attend within 24 hours after death To the Funerel Director; completely filled in by the	edical Ce	(Check only 2 Medical Exam	rsician: To the best of my k iner: On the basis of exami	nowledge, deati	h occurred at the ti	me, date and place	, and due to the ourred at the time, o	cause(s) and manner as date and place, and due	stated. to the cause(s)
)	To the within 2-	Med	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date signed (Month	
	(3)		30. Name and address of person who c	ompleted cause of death (It	em 23a) (Type,	Print)				
-	Sta Regist		31. Date filed (Month, Day, Year) JAN 14 200	39. Registrar's Sig	nature dos	de		,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Year **Physician** 9:30 2004 Marcellus L. Savoy December 31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Ruxton Nursing Home
Social Security Number 6. Sex Denton If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 11€M 2□F Hours 59 Yrs. 212-44-7032 Director 1945 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a, State 28a-f show avent, the Medical Examiner must be notified at 1 ☐ Yes 2X No Maryland Caroline Denton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5 239 405 405 Chuck Ave 21629 USA Apt. Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 3€ No Specify: Specify: Black à If Yes, Give Year or Dates: 3 Widowed 4 Divorced netural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 8th Laborer Johnson Lumber Co. if Health and Mental Hygie Itam 27 Is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked othe any liuly or other traumatic avent. 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Patricia N. Sorrell William I. Savoy 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Savoy(Sister) Hurlock, Md. 21643 302 Wright's Ave 20b. Place of Disposition (Name of Be streets) 1 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 1-12-05 Annapolis, Md. Park 22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee Larry D. Neese MO0483 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, neach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ETASTATIL /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medicai the the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physiclan: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 25 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c, injury at Work? 28d. Describe how injury occurred After or Attending Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death | Diractor: filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D0053094 TYENDING FRARKES BURGI (Item 23a) (Type, Print) 30. Name and addre of pers loomingda

DHMH 17 Rev 1/2001

State

Registrar

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\$2. Registrar's Signature

			For Amend Items 23	State of Manylan	d ₃ / ₉ Depa Cei	TRESTAN	dealth and Death	d Mental Hy	rgiene 004	42948
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last)	Marvin C.	Span	gler		2. Date of De Month	Day Year 28 200	3. Time of Death 10:45 PM
	Examin		4a. Facility Name (If not institution, give s FRAN KUN SQUARE 5. Social Security Number 6. Sex	HOSPITAL CE.		4b. City, Town, of Rose	EDALE If Under 24 I		4c. County of Dea	MORE thplace (State or Foreign
	Director		Usual Residence of Decedent	M 2□ F 7 5			710010		14,1928 ¹	guntry)
	e Marylar a-f show lifted at	ctor	MD Baltim		y, Town or Lo	Essex				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the	ai Dire	10e. Street and Number 715 Dorsey Ave			10f. Zip Code 2122	1		10g. Citizen of What C	ountry?
36	urs after deat al', or items 2	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ ♥ Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of I f Yes, specify Cub I ☐ Yes 2 No	an, Mexican, Pu	(Specify Yes or Nierto Rican, etc.)	o- 14. Race - Am Black, Whi	te, etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Importent: If Item 27 is marked other than "neturel", or items 23e or 28a-f show any injury or other treumatic event, Ite Modical Examination unit or notified at anone.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire Ck Driv	during most of d)	working	16b. Kind of Business Transpor	•
yland 2	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Clair Spangler					Name (First, Middle Haven	, Maiden Sumame)	
	nd 2 sho aith and 27 is ma r treuma		19a. Informant's Name/Relationship (Type Karen Martin /f	*					ner, City or Town, State,	
Baltimore,	Pages 1 and the pages 1 and the pages 1 and the pages 1 and		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 💆 R. 4 ☐ Donation 5 ☐ Other (Specify)		emetery, crem •Olive	sition (Name of natory or other pla etCemet	ery 12		20c. Location - City of Hanover	PA
Balt	permit. Departr Importe any inj		21. Signature of Funeral Service License	annell	11	300	масе	AVE Ba	FuneralHo ltimore M	meofEssex D 21221
8760,	Prysician //Medical Examiner	dicai Examiner	23a. Pert1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con-eq	OCARD juence of): juence of):	DIAL IN	ARCTION		<i>1-</i> ,	Approximate Interval Between Onset and Death
P.O. Box 68	death certific e attending p ed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pregnance Other (specify)			23d. Date of de Month	olivery Day Year
	w requires that the sbeen signed by the should be detached	ed by Ph	Part II. Other significant conditions con	- PITTO / 100	-	nderlying cause gr			tobacco use contribute t Yes 2ÅNo 3□P	o the cause of death?
Division of Vital Records,	The law ate has b page 2 s	Completed by	Retroperitoneal b	oleed/hematoma	a compl	licating		24a. Was auto perf 1 \(\triangle Yes	ppsy prior to ormed? death?	utopsy findings available completion of cause of
Vita	Physicien: The this certificate ral director, page	To Be (25. Was case referred to medical examiner? 1 Yes 2 → No	ospital: 1⊠Inpatient 2□] ER/Outpatien	it 3□ DOA Ot	nor	Death (Check only	one)	acifu)
ion of	ing		27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju			how injury occurred	sury)
Divis	or Al fter c Direc in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str fy)	eet, factory, office		28f. Location City or To	(Street and Number or R wn, State)	lural Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical	29a. Certifier 1 💢 Certifying Physical (Check only one) 2 Medical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or in	n occurred at the to vestigation, in my	me, date and pl opinion, death o	ace, and due to the ccurred at the time.	cause(s) and manner a , date and place, and du	s stated. e to the cause(s)
)	To the To the comp	M	29b. Signature and title of certifier MUSSIN A	th'mo			se number		29d. Date signed (Mon	th, Day, Year)
_	6		30. Name and address of person who co Dr. WASSIM EL-HITT	1,9000 FRANI	KLIN SI	QUARE D	RIVE, B	ALTIMOR	CE, MD 2	1237
	Sta Regist		JAN 1 8 2005	32. Registrar's Signa	Hosel					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Dmith 30

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

1 Yes 2 No

Physician /Medical Examiner

Director

Completed by Funeral

Be 2 For State Registra

Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed the attending physicien funeral director, page 2 should peen After this certificate has death. after death Director: the within 24 hours at To the Funeral D

P.O. Box 68760

Division of Vital Records,

Examiner Physician/Medical þ Be Completed Certification: To filled in by Medical

ober 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Hal turans Home 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) Min. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location BALTIMORE BALTI MORE 10g. Citizen of What Country? 10e. Street and Numbe USH Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 2 No 1 🗌 Yes Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BARTENDER SERVICE Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239 9402 BALTIMORE MO Thorne wood 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ R
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Nan 20c. Location - City or Town, State 1-3-05 21. Signature of Funeral Service Lice 22. Name and Address of Facility BACTI MORE, MO 21234 EVHOS FUNGELAL CHAPEC . 8800 HARFORD IRP Part1. Enter the disease, o comshock, or heart failure. List only Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last antronson Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 200 1 🗌 Yes

3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 1 | Inpatient 3 DOA of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Linatural Injury 5 Pending 2 No investigation 1 ☐ Yes 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD W.MO W D0060120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Flagethmn Too

32. Hegistrar's Signature Hospital Rd Prince Frederick wast

State Registrar 31. Date filed (Month, Day, Year) 4 R. Marson

State of Maryland / Department of Health and Mental Hygiene Reg. No. 4 U U 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Year Physician 2 2004 /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner USA 7. Age (In yrs. last birthday) | Munder 1 Year Honore ARRE ANDIOWN-8. Date of Birth (Month, Dey, 9. Birthplace (State or Foreign Country) MARY AND 5. Social Security Number **Funeral** Sex 1 M 2 □ F Months Days Yrs. 28-0221 216-AND Director Usuel Residence of Decedent death with the Meryland 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryle Depertment of Heelth and Mental Hygiene. Important: if Item 27 ie marked other than "naturel", or frema 23a or 28e-1 ehoventy injury or other treumatic event, the Medical Examinar must be notified at 1 Yes 2□No MD Baltimore Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 24 Funeral 14. Race · American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Armed Forces?

1 M Yes 2
If Yes, Give
Year or Dates: 2 □ No 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 🗷 No Specify: altimore, Maryland 21215-0036 Specify: BACK ۾ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) ARRABBER 18. Mother's Name (First, Middle, Maiden Surname) 17 Fether's Neme (First Middle, Last) Lillie Bses 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) WAY Alumore Bathmore MD 21224 GINA cuanter MUPSON 6202 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State CEMETE GREENMOUNT 4 Donation 5 ☐ Other (Specify) 21. Signature Uneral Service Licenses 22. Name and Address of Fecility IRVIN P CARROLL FUNERAL HOME 1712W. NORTH AVE. 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or es a consequence of): Examine nding physician end use as the buriel-transit The lew requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of): ettending p ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detech 3 Probably 4 □ Whknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed pege 2 s 20100 1 ☐ Yes P☐ No 1 ☐ Yes certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 1 Yes 20 No 2 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA filled in by the funeral dis 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Neturel 5 Pending investigation 1 Tes 2 No 2 ☐ Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funerel C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edicai 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner steted. To the 29d. Date signed (Month, Dey, Year) License number 29b. Signeture end title of certifier 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) f egistrer's Signeture 31. Dete filed (Month) Y041) 3 2005 32. State Registrar

ORIGINAL

DHMH 16 Rev 6/95

		- For Amend Item 25 Registrar 1. Decedent's Name (First, Middle, Last)	per ME, G838,	12/23/04dh Certifica	te of Death	2. Date of Dea	ith	3. Time of Death
Physici /Medi		Harry Tate Jn.				November		
Examir		4a. Fecility Name (If not institution, give s Johns Itopkins Bayview	are (cnter		Town, or Location of De	0 0 0 0	4c. County of Dea Baltim	
Funeral Director		5. Social Security Number 6. Sea 220-66-0924		last birthday) If Und	er 1 Year If Under 24 h	In. 8. Date of Birth (Month, Day 8 / 25	h O Rie	hthplece (State or Foreign ountry) RYLAND
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Location				10d. Inside City Limits
ith the Marylan or 28a-f show	tor	MD N/	A	BALTIMOR	E			1 Yes 2 □ No
or 28	Director	10e. Street and Number	AND AND	10f. 2	Cip Code		10g. Citizen of What C	ountry?
seth wi	Funeral		ANT AVE. 12. Was Decedent Ever in U	.S. 13. Was Dec	21224 redent of Hispanic Origin? becity Cuban, Mexican, Pu	(Specify Yes or No-	USA 14. Race - Am	erican Indian,
filed within 72 hours after deeth with the Maryland Hygiene. Hyber than "natursi", or Items 23s or 28s-f show ant, the Medical Examinat must be notified at	þ	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		pecify Cuban, Mexican, Pu 2囚 No Specify:	rèrto Rican, etc.)	Specify:	WHITE
72 hou natura	Completed	15. Decedent's Edu (Specify only highest grad	cation completed)	16a. Decedent's Us (Give kind of y	vork done during most of	working	16b. Kind of Business	s/Industry
within ene. than "	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Viife. DO NOT	use retired)		AUTO	
d 2 should be filed with th and Mental Hygiene. 77 Is marked other than traumatic event, Iran.	Be Co	17. Father's Name (First, Middle, Last)		TILOI		Name (First, Middle,		
should be nd Mental marked c	To B	HARRY TATE, S	SR.			TTY STRO		
2 sho and I Is ma		19a. Informant's Name/Relationship (T)		Aur	ss (Street and Number of			
C = :		MRS. SHARON ROT	20b. 1	Place of Disposition (Acemetery, crematory o	lame of	Date	LTIMORE, 20c. Location - City o BALTIMOR	
permit. Pages 1 a Department of Hez Important: If Itsm any injury or oths once.		21. Signature of Funeral Service Licens		/ KACZC	ROWSKIFacifu DUNDALK A	NERAL HO	ME P.A.	NO SACROPERATORIA
Physician		23a. Pert1. Enter the disease, rr. mp shock, or heart failure. Let only of Immediate Cause (Final disease or condition	ications that caused the dealer cause on each line.	n. Do not enter the m	ode of dying, such as car	diac or respiratory ar	rest.	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death) Sequentially list conditions.	Due to (or as a consecutive to for a consecutive to	5 kg - 0	nd-		1	decades
xecuted n and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiated events resulting in death) Last	Due to (or as a conse	s C				decades
ificate be executed g physician and as the burial-transit	edical E		tintraver		asuse	OVENEDICAL E	EXAMINER	decades
The law requires that the death certificate has been signed by the attending age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	ancy al death 3 ☐ Ectopic death 5 ☐ Other	pregnaceRTIFICATION API	PROVED BY WALL	23d. Date of do Month	elivery Day Year
uires that I n signed by	by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the underlyin	g cause given in Part I.	23e. Did to	obacco use contribute Yes 2 ☑No 3 ☐ F	to the cause of death? Probably 4 □Unknown
stcian: The law requires t recriticate has been signe irector, page 2 should be o	Completed						ormed? prior to	autopsy findings available completion of cause of
alcian: Th certificate irector, pag	Be	25. Was case referred to medical examiner?				Death (Check only o	one)	
Phy ald	2	1 Yes 2 No. 27. Manner of Death 1 Natural 5 Pending	1 Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	DOA Other: 4 Nursin 28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe I	dence 6 Other (Sp how injury occurred	ecify)
To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, street, fact ify)			Street and Number or I wn, State)	Rural Route Number,
ne Hospita 124 hours 1s Funere letely fille	Medical C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	rsician: To the best of my kr iner: On the basis of examin and manner stated.	nowledge, death occurr nation and/or investigati	ed at the time, date and poon, in my opinion, death o	place, and due to the occurred at the time,	cause(s) and manner adate and place, and di	as stated. ue to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mor	nth, Day, Year)
		LISA GUN)	MID		D57768		11/17/04	
23		30. Name and address of person who of Lisa Boult	10 5505	Hophus B	ayvew (wde	Baltrus	ne MD ZI	224
S Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	Sports		1		

			AMEND ITEM #29c P	PER DVR G839					•	Reg. No.	004	429	152
П	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of De Month	Dev	Year	3. Time of Dea	
-	/Medic	al	Helen Winterfeld							er 25,	2004	7:50 PM	1
1	Examir	er	4e Fecility Neme (If not institution, give s				1	4b. City, Town, or I					
			Randolph Hills N			fav) If Under		Silver Si			tgomer		
•	Funeral Director		377-10-2341		yrs. last birtho	Months	Days	Hours Min.	May 30	th y, Year) , 1914	9. Birthplace Country Virgin	e (State or For nia	reign
	end *	1	Usual Residence of Decedent 10a. Stete 10b. County	10c	City, Town o	r Location					10d.	Inside City Lir	mits
	Many February	ঠ	MD Montgome	ery	Silve	er Spri	ng					1 □ Yes 2 📉	No.
	r 28a	5	10e. Street end Number			10f. Zip	Code			10g. Citizen of V	Vhat Country	?	
	th wit	ai D	4011 Randolph Road	1			20	902		USA			
020	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at angle.	To Be Completed by Funeral Director	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	n U,S.	13. Was D <i>ec</i> ed If Yes, spec 1 ☐ Yes		lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		e - American k, White, etc. white		
2-0	72 hc	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	16e. De	ecedent's Usua Sive kind of wor	I Occup	nation during most of world)	rking	16b. Kind of Bu	siness/Indus	try	
121	ne ne ne ne ne ne ne ne ne ne ne ne ne n	ם	Elementery/Secondary (0-12)	College (1-4or 5+)			se retire	d)			, DM		
i D	Hygie her ti	ပိ	17. Father's Neme (First, Middle, Last)		C	lerk		18. Mother's Nar	ne /First Middle		ADT		
an	d be f	Be	John J. Thompson						e Smith	maio di Comani	٠,		
<u> </u>	or Me	ř	19a. Informant's Name/Relationship (Typ		19b. M	failing Address	(Street	and Number or Ru		er. City or Town.	State. Zip Co	de) 2090	76
S	od 2 stranger tranger	ĺ	Burnette Capshaw/s	•		_		re World		-		200	
Baltimore, Maryland 21215-0020	Peges 1 en ment of Hea ant: If item 3 ury or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re 4 ☑ Donation 5 □ Other (Specify)	emoval from State	b. Place of D cemetery,	isposition (Nan crematory or o			Date	20c. Location -	-	74	
Balti	permit. Departminents Imports any inju		21. Signature Funeral Service License On a Lu S W	ade / Direct	or	22. Name an State A Baltimo	Anat	omy Board		Baltimo	ore St	reet	
			25a. Pan 1. Enter the disease, or complice shock or heart failure. List only one	cations that caused the c						rrest,	Ap	proximate erval Between	1
1	Physician /Medical		Immediate Cause (Final disease or condition			rtery d						nset and Death	
	Examiner	_	resulting in death) a.			nsequence of):			,		i i		
	ed sit	Jue	b.								i i		
Ö,	e exacut ien end uniel-tren	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due t	o (or as a cor	nsequence of):							
68760,	rtificate be executed ng physicien and set the buriel-trensit	Medica	resulting in death) Last	Due t	o (or as a con	sequence of):					i i		
Box	ath ce ttendi or use	Physician/M	d.			-					1		
P.O.	the e	/sic	Part II. Other significant conditions cont	tributing to death but not	resulting in th	ne underlying ca	ause giv	ren in Part I.	23b. Did	tobacco use cor	tribute to the	e cause of de	ath2
۳.	thet the	by Ph	alzheimers di	isease					10	Yes 2□ No	3 Probab	ly 4 ⊡ Unki	nown
Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours and redeath. Within the Funerial effector: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be deteched for use as the bunel-transit	Completed b							24a. Was perfo	an autopsy rmed?	availal	autopsy findin ble prior to etion of cause th?	_
ř	The la	Ë							(42)	Yes 2010	1 □ Y	es 2□No	
Ħ	lan: ortifice ctor, I	Be	25. Was case referred to medical examiner?						ath (Check only o	one)			
<u>></u>	hysic nis ce I dire	P	1 ☐ Yes 2 X No		2 ☐ ER/Outpa		_	4 Shi ursing H	ome 5□ Resi	dence 6 🗆 Oth	er (Specify)		
Division of Vital	Attending Physician: or deeth. actor: After this certific by the funerel director,	ation:	27. Menner of Death 1 MaNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	r) 28b. Tim Inju	ie of 2	8c. Injur Wor 1 □	yet k? Yes 2 □ No	28d. Describe	how injury occurr	ed		
Divis	tal or Atters effects al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Injury - / building, etc. (Sp	At home, farm ec <i>ify)</i>	, street, factory	, office		28f. Location (: City or To	Street and Numb wn, State)	er or Rural Ro	oute Number,	
	To the Hospital within 24 hours of the Funeral completely filled	edicai	29a. Certifier (Check only one)	iclan: To the best of my er: On the basis of exan and manner stated.	knowledge, d nination end/o	eeth occurred or investigation,	et the tir in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place, a	nner as state and due to the	d. e cause(s)	
_	Nithin Nithin Fo the	Me	29b. Signature and title of certifier	2 1	\cap	290	. Licens	e number		29d. Date signed	(Month, Day	r, Year)	
) (1) W	lond	//	V	D522	D52761			1-11-0	5	
		-	30. Neme end address of person who con	moleted cause of death (Item 23e) (Ty		אל לע	1.0		2-1			
			allan K. x	rejax		Delne	n	speri	ny,	iria.			
	* Sta Registr		31. Date filed (Month, Day, Year)	32. Registrer's S	ignature	Comment of the		,					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar/Amend#5.Per FH PCC 1-10-05 cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 7:51A M Harvey Maurice Awkard Dec. 27 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton
Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Southern Maryland Hospital Prince Georges 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 → M 2 □ F Months Director 76 5/30/1928 MD 16 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, if a Madical Examinar must be notified at 1 Yes 2 No Director P.G. MD Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3920 Park Blvd death Funerai 20746

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after Types 2 No
If Yes, Give 6-19-46Year or Dates 6-10-66 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 Divorced Black Ī9**-**66 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. int: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Private Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Agustus Harvey Awkard Ella Benson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3920 Park Blvd. Suitland, Md. 20746

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Tov Allean Awkard/wife 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. MD. Vet. Cem 1/5/05 Cheltenham, MD. *4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Hodges and Edwards 21. Signature of Funeral Service Licensee wards 3910 Silver Hill RD.Suitland, MD. 23a P.rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE MYDEARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? PULMONARY CHRONIC OBSTRUCTIVE DISENSE 24a. Was an page 2 autopsy performed TNEUMON, A 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 1 Inpatient 2 DER/Outpatient 3 DOA funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours 1 cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 and manner stated 500 Rus 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DECEMBER 27, 2004 D40324

State

TERRY 31. Date filed (Month, Day, Year) JAN 0 6 2005 Registrar

2. Registrar's Signature

ress of person who completed cause of death (Item 23a) (Type, Print)

JODRIE, M.D.,

7503 SURRATIS ROAD, CLIWTON, MARYLAND

20735

Physician	State Registrar per M.D., TCHD, 01/03/05 Decedent's Name (First, Middle, Last)	s, sbb Certificate of Death	Reg.	No. UUI	3. Time of Death
/Medical	BERTHA J. BLUSH Bertha I	. Blush		26 2004	2:00 PM
Examiner	Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dear	h	4c. County of Death	
	WILLIAM HILL HEALTH CARE Social Security Number 6. Sex 7. Age (/	EASTON In yrs. last birthday) If Under 1 Year I If Under 24 Hrs	8. Date of Birth	TALB	
uneral irector		O Yrs. Months Days Hours Min		1914 WAS	place (State or Foreign intry) HINGTON DC
thow	a. State 10b. County 1	0c. City, Town or Location			10d. Inside City Limits
"natural", or Items 23a or 28e-f show adical Examiner must be notified at leted by Funeral Director	MD TALBOT	EASTON			1 □ Yes ¾ □ No
in items 23a or 28e-1 s	e. Street and Number 8515 DEEP COVE RD	10f. Zip Code 21601	10g.	. Citizen of What Cou USA	intry?
nera	Marital Status 12. Was Decedent Eve		specify Yes or No-	14. Race - Amer	
by Fur	Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puer 1 □ Yes 2 No Specify:	to Rican, etc.)	Specify: WH	
or other treumatic svent, the Madical Examinat must be notified at To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo	rking 16t	b. Kind of Business/li	ndustry
dwo	Elementary/Secondary (0-12) College (1-4or 5+) 1 2 0	SEAMSTRESS	CII	STOM SHIR	T MAKING
event, I Be Co	. Father's Name (First, Middle, Last)		me (First, Middle, Mai		I IIIIII
To B	WILLIAM F. KIDD	GEORGI	A WINDSOR		
	a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or R		•	ip Code)
The T	NANCY L. WOLF/DAUGHTER a. Method of Disposition	8515 DEEP COVE RD.,		D 21601 c. Location - City or T	Court State
	1X Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crematory or other place)			
<u> </u>	` 4 □Donation 5 □ Other (Specify) I. Signature of Funeral Service Licensee	WASHINGTON NATIONAL CEM 1 22. Name and Address of Facility	2-29-2004	SUITLAND	• MARYLAND
any injury or o	JOHN R. MERCE	FELLOWS, HELFENBET	N & NEWNAM	FUNERAL	HOME PA
	3a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	200 DT INXINITUON OF	c or respiratory arrest,	<u> </u>	Approximate Interval Between
ian	nmediate Cause (Final sease or condition	mention diskemen	Tand		Onset and Death
eal er	sulting in death) Due to (or as a c	consequence of):	11		1007
	equentially list conditions, any, leading to immediate Due to (or as a c				
Examiner	equentially list conditions, any, leading to immediate uses. Enter Underlying uses (Disease or rijury at initiated events c.	onsequence off.			
burial-transit	at initiated events c	consequence of):			
<u>m</u>	d				
Medi	FEMALE:				
Physician/Medical	b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	Fetal death 3 Ectopic pregnancy		23d. Date of deliving	very Day Year
be deta	rt II. Other significant conditions contributing to death but r	not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ed b	My pertensin		1 ☐ Yes	2-21√No 3 □ Pro	bably 4 Unknown
Completed	End Stage Ruel 1	csarl	24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
. 15	O		performed	death?	•
Se S	. Was case referred to medical		ath (Check only one)		
Be Cor	examiner?		lome 5 Residence		ify)
To Be Cor	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient		29d Deceribe how i	injury occurred	
funeral director, pag tion: To Be Cor	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Y	28b. Time of Injury Work?	28d. Describe how i		
by the funeral director, pagint cation: To Be Cor	1	28b. Time of Injury at Work? M 1 Yes 2 No - At home, farm, street, factory, office	28f. Location (Stree	et and Number or Rui	ral Route Number,
Certification: To Be Cor	1 Yes 2 No Hospital: 1 Inpatient Manner of Death 1 Natural 5 Pending (Month, Day Y) 2 Accident investigation (Month, Day Y)	28b. Time of Injury at Work? M 1 Yes 2 No - At home, farm, street, factory, office		et and Number or Rur State)	ral Route Number,
pletely filled in by the funeral director, pagedical Certification: To Be Cor	Hospital: 1 Inpatient	28b. Time of Injury at Work? At home, farm, street, factory, office The specify of the street of t	28f. Location (Stree City or Town, S	itate)	stated.
completely filled in by the funeral director, pag Medical Certification: To Be Cor	Hospital: 1 Inpatient Manner of Death Manner	28b. Time of Injury at Work? At home, farm, street, factory, office The specify of the street of t	28f. Location (Stree City or Town, S a, and due to the caus urred at the time, date	itate)	stated. to the cause(s)
completely filled in by the funeral director, pag Medical Certification: To Be Cor	Hospital: 1 Impatient	28b. Time of Injury at Work? M 1 Yes 2 No - At home, farm, street, factory, office my knowledge, death occurred at the time, date and place tamination and/or investigation, in my opinion, death occurred. 29c. License number th (Item 23a) (Type, Print)	28f. Location (Stree City or Town, Stree City or Town, Streed at the time, date 29d.	e(s) and manner as and place, and due	stated. to the cause(s)
ral Director: After this certification by the funeral director Certification: To Be	Hospital: 1 Impatient	28b. Time of Injury at Work? At home, farm, street, factory, office The street of the time, date and place that the time, date and place that the time and street of the time of the tim	28f. Location (Stree City or Town, Stree City or Town, Streed at the time, date 29d.	e(s) and manner as and place, and due	stated. to the cause(s)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrer 1-6-05 Amend#23a.Prt.1.Per Phys.Pg Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year 13 aceman2 arius 2004 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospita Contamery Montgamer Jereral Ineu 5. Social Security Number if Under 1 Year 6. Say Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Bithplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F 69 Director New Castle, 221-22-0491 02 - 08 - 35Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 TyYes 2 □ No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15309 Durant Street filed within 72 hours after death Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ②AYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: 3 → Widowed 4 □ Divorced Be Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Hygiene. other than Principal Montgomery County School Pages 1 and 2 should be filed v then of Health and Mental Hygie tant: If itam 27 is marked other t jury or other traumatic avant, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward H. Brown Clara B. Byard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly B. Moss/Daughter 15309 Durant St. Silver Spring, Md. 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Removal from State 3 Removal from State permit. Page Department o Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 1-3-05 Silver Spring, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityMarshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011 Rnaukall 23a. Park. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration Pneumonia minutes disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner stoperativ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a co The law requires that the death certificate be executed Don that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death P.O. F 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 2 Medical Examiner: 29b. Signature and title of certifler 0 30. Name of person who completed cause of death (Item 23a) (Type, Print) Fran 3416

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day

2. Registrar's Signature

(buy)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** December 27 2004 12:30 DOROTHY BASS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGES BRICKER DRIVE WASHINGTON 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year 8. Date of Birth OCT., 27,1926 9. Birthplace (State or Foreign Country) South Carolina **Funeral** Months Days Hours 1 □ M 2 🕅 F 78 Yrs. **Director** 251-32-0744 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow or items 23a or 28a-f ehov other roust be outlified at TOP STREET AND 10e. Street and 10e. Street and 11. Marital Statu 1 Never M 1 √Yes 2 No PRINCE GEORGES FT. WASHINGTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygene. important: If item 27 is marked other than "natural", or items 23a any highry or other traumatic event. If a Medical Exterined frust once. BRICKER U. S. A. DRIVE 20744 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 22 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify Be Completed by 3 Widowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSE KEEPING- SUPERVISOR GOV, T 11 th
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BENNIE GIBBS MENDORA OUTING 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE ANN BOLDEN-DAUGTHER 705 BRICKER DRIVE FT. WASHINGTON MD. 20744 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State WASHINGTON NATIONAL JAN.,04,05 SUITLAND, MD. 4 □ Donation 5 □ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility TOPE FUNERAL HOMES 5538 MARLBORO PK. FORESTVILLE, 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD.,20747 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer of Breast Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician a for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Multiple Myeloma Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a Wasan certificate has autopsy performed? 2**K** No 1 Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner Hospital: 1 Inpatient 1 ☐ Yes _2 Ho Other 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 2 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred After t Certification: Injury at Work? Hospital or Attending 5 Pending after death. 1 ☐ Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a 29a. Certifier f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 200. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23743 1-3-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greehbett MD De Greenway Or 1222 MARIK 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month Year Dion Beckwith James 5:00 A.M December 31. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millennium Of Forestville N.H. Forestville Prince Georges | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 28, 1964 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Washington, D. C. **Funeral** 1√2 M 2□ F 577-92-1439 40 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28e-f show the Medical Examinar must be notified at 1√2 Yes 2 No Directo Maryland Prince Georges Forestville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20747 3106 Lakehurst Ave. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1≱1Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Research Assistant Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other treumatic event <u>once</u>. Be James Snow Iva Lee Kenan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3106 Lakehurst Ave. Forestville, Md. LaTaunja Beckwith / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Jan. 6,2005 Landover, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Alexander S. Pope Funeral Homes, P.A. Pike/Forestville, Md. 20747 201085 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral Toxoplasmosis /Medical Due to (or as a consequence of): Examiner Human Immunodeficiency Virus Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown á signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' certificate 2 No 2 🗆 No 1 ☐ Yes or Attending Physicien: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 3 € No Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel C 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0026024 January 4, 2005 30. Nume and address Merson who completed cause of death (Item 23a) (Type, Print)
Lester Miles, M.D. 6490 Landover Rd. Suite F Landover, Md. 20785 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JAN 0 6 2005 Registrar

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	Discolati		Decedent's Name (First, Middle, L.	ast)							Date of Death Month	Day	Year	3. Time of	f Death	
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*	Funeral					. last birthday)	If Under		Hours	Hrs. 8. D	Date of Birth Month, Day, Ovember	(ear) 9	13 9. Birth	place (State o	or Foreign	
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i	Physici /Medio		1. Decedent's Name (First, Midd Reena	le, Last) Ruby		Bere	nson				2. Date of De Month Decemb	ath		ear 004	3. Time of 12:4	
1	Examir		4a. Facility Name (If not institution Montgomery Ger	neral Hospi	ital	one hinth day.	4b. City, T	ey	Location o		0.0	Mo	County of	ery		
	Funeral Director		5. Social Security Number 007-22-0599 Usual Residence of Decedent	1□M 2ਊF		71 Yrs.	Months	Days	Hours	Min.	8. Date of Bin (Month, Da Oct. 2	y Year)	.933 N	. Birthp Coun Iew	lace <i>(State</i> of try) Jersey	r Foreign
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36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Itam 27 is marked other than "netural", or Items 23e or 28e-f show other traumatic avant, the Macilcal Exercitiest in the Instituted at	by Funeral I	14508 Homecrest 11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	12. Was Deced	dent Ever in U.S ces? 2 🙀 No	'	Vas Decede f Yes, speci 1 □ Yes 2	ent of His rfy Cuban	panic Orig , Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No lican, etc.)	U.S	14. Race - Black, Specify:	White,		
Maryland 21215-0036	d within 72 hou giene. ar than "netura ur e Mauleal E	Completed	15. Deceder	nt's Education st grade completed) College (1-		16a. Deced (Give life. I	dent's Usual kind of work DO NOT use aker	l Occupat k done du e retired)	tion uring most	of workin	g		ind of Busin	ness/Ind		
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altimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (5	3 □Removal from S	20b. Pf	ace of Dispo emetery, crem g Davi	sition (Name natory or oth	e of her place)	Da	ite	20c. Lo	cation - Cit s Chu	y or To	wn, State	
Balt	permit. Departitimport		21. Signature of Funeral Service	The		11	800 N	ew H	ampsh	ire	S-RINA Ave. S	ilve				
	Physician /Medical		23a. Party Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	r complications that ca t only one cause on ea a	ch line.						respiratory ar	rest,			Approximate Interval Betwoonset and D	ween Death
	Examiner	e.	Sequentially list conditions,		tabelia ir as a consequente cute					د					Ince	(C
8760,	cate be executed physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<u>ξ</u>	r as a consequence		SEP.	512						-	2 wel	-14
.O. Box 68	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	Physiclan/Medlo									23d. Date of delivery Month Da			-	'ear	
<u>a</u>	w requires that i been signed by should be deta	þ	Part II. Other significant condition Diabetes	ons contributing to dea	ath but not resul	Iting in the ur	nderlying ca	use giver	n in Part I.		23e. Did to				e cause of de	
al Records,	i ician: The law requ certificate has been rector, page 2 shoule	Completed									24a. Was a autop perfor	sy	24b. Wer prior deat 1 🗆	h?	sy findings a pletion of car	vailable use of
f Viital	nysician: ns certifica director,	To Be	25. Was case referred to medical examiner?	Magnitals > /	patient 2□E	ER/Outpatien	t_ 3□ DOA	_			Check onl o		3 □Other (Specify)	
Division of	To the Mospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	gation	, Day Year)	28b. Time of Injury	м	c. Injury a Work? 1 □ Ye	at	28	3d. Describe h					
<u>N</u>	To tha Hospital or Attendin within 24 hours after death. To tha Funeral Diractor: Af		4 ☐ Homicide determ	nined 286. Place of building	of Injury - At hong, etc. (Specify))					Bf. Location (S City or Tow	n, State				er,
	ha Hos in 24 ho ha Fun pletely f	Medical	one)	ng Physician: To the bas Exeminer: On the bas and manne	er stated.	on and/or inv	estigation, ii	п ту орн	nion, death	n occurred	at the time, o	ause(s) late and	and manne place, and	r as sta due to	ted. the cause(s)	
)	To T com	Σ	29b. Signature and title of certifie	01005/10	M)		29c.	License i	number	245	- 2	i	e signed (M	conth, D	ay, Year) 200 9	4
	-		30. Name and address of person 7573 New 1	who completed cause	of death (Item	23a) (Туре, I	Talo	mo	Pa	wk	on c	20	31,1	no	FACE	,
	Sta Registr	te ar	30. Name and address of person 7573 New (31. Date filed (Month, Day, Year)	5 2005	gistrar's Signatu	& A	rede									

			State of Maryland / Departs For Amend Items 25,27,282-f per Mr. G85 - State of Maryland / Departs For Amend Items 25,27,282-f per Mr. G85 Certific	ment of Health and Men 19 01/18/05dhb icate of Death	ntal Hygier	ne2004	42960						
			Decedent's Name (First, Middle, Last)		Date of Death		3. Time of Death						
	Physicia		Sister Ambrose Byrne		Nov. 22	ο 2004 γεατ	2:25 A. M						
7	/Medic Examin		4a. Fecility Name (If not institution, give street and number) 4b.	. City, Town, or Location of Death		4c. County of Death							
				Emmitsburg		Frederio	2k						
	Funeral		S. Social Security Humber	Under 1 Year If Under 24 Hrs. 8. 1 onths Days Hours Min.	Date of Birth (Month, Day, Yea	ar) 9. Birthp	plece (State or Foreign htry)						
	Director		215-54-3767	\$e ₁	pt. 23,	1909 Vi	rginia						
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locatio	on		1	Od. Inside City Limits						
	f sho	5	MD Frederick Emmitsbur	o			1 ☐ Yes 2 ☐ No						
	28a-	Director		Of. Zip Code	10g.	Citizen of What Cou	ntry?						
	3a or		335 South Seton Avenue	21727		U.S.A.							
	Heath	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (Specify s, specify Cuban, Mexican, Puerto Rica	Yes or No-	14. Race - Americ Black, White.							
G	or Ite	교	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	Yes 2 No Specify:	an, etc./	Specify:	eic.						
ğ	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do thygiene. do ther than "natural", or items 23a or 28a-f show event, the Madical Examinar must be notified at	l by	If Yes, Give 1 ☐ N 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Tes ZXX No Specify.		Whi							
ς. Ο	72 h	Completed	(Specify only highest grade completed) (Give kind	s Usual Occupation of work done during most of working		. Kind of Business/In							
7	Athin ne.	ш	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired)		eligious (_						
7	filed w Hygie other th	ပိ	College 5+ Nurs 17. Father's Name (First, Middle, Last)	18. Mother's Name (Fi			of Charity						
anc	ntai H ed of	Be		Nellie R									
Ë	should be nd Menta i marked umatic ev	ဥ	Ambrose Carey Byrne, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ac	ddress (Street and Number or Rural Ro			Code)						
Maryland 21215-0036	ith and 2 s ith and 27 is 27 is trau			. Seton Avenue, Em									
	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke nny injury or other traumatic anse.		20a. Method of Disposition 20b. Place of Disposition cemetary, cremator	n (Name of Date	20c.	Location - City or To	own, State						
Baltimore,	Page ent o nt: If ry or		1 🖾 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) ST. JOSEPH ST. JOSEPH	11 /07 //	04 EM	MITSBURG,	MD. 21727						
atti	mit. partm porta y inju		21. Signature of Funeral Service Licensee 22. Na	ame and Address of Facility SKI	LES FUNI	ERAL HOME							
m	80 5 8	l		O W. MAIN ST. EMMI		MD 21727							
	/Medical Examiner	miner	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, styck, or heart failure. List only one pause in each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, frany, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
	execun and and ial-tra	Examin	that initiated events c. resulting in death) Last Due to (or as a consequence of):	D Miner	BY MEDICAL								
8760,	ate be executed thysician and the burial-transit	icai	d	ON APPROVE									
Ö	ng ph as th	Jedi	IF FEMALE:	TOTIFICA.		1							
О. Вох	that the death certifica ed by the attending pt detached for use as ti	Physician/Med	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ector	opic pregnancy her (specify)		23d. Date of deliv Month	ery Day Year						
rds, P	8 5 9	ρ	Part II. Other significant conditions contributing to death but not resulting in the under	tying cause given in Part I.	23e. Did tobacc	co use contribute to t 2 ⊠No 3 ☐ Prol	he cause of death? bably 4 DUnknown						
Vital Records,	The ate h page	Completed	Phigheral Vascula	Dislore	24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of 2 No						
ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (C	Check only one)								
of V	Physic this co	ျှ	1 ☐XYes 2X No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3			6 Other (Special	<i>(</i> ن)						
ū	Ter Ter	0	27. Manner of Death 28a. Date of Injury 28b. Time of Injury (Month, Day Year) 1	Work?	d. Describe how in Subject f								
Sic	Attending r death. ector: After by the fune	icat	2 Xaccident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street,	1 44		and Number or Run	al Route Number.						
Division	al or Attendir after death. I Director: Af d in by the fu	Certification:	4 Homicide determined determined building, etc. (Specify)		City or Town, Si	^{tate)} Emmitsh eton Avenu	ourg,MD						
_	Hospita 4 hours Funera tely fille	edical C	29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, death occ 2 Madical Examiner: On the basis of examination and/or investigand mapper stated.	curred at the time, date and place, and	due to the cause	e(s) and manner as s	stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certified	29c. License number	29d.	Date signed (Month,	Day, Year)						
	- > - 0		I What annoll	1 1/1870) NO	VEMBER 22	, 2004						
₹	İ		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	W .									
				., EMMITSBURG, MD.	21727								
	Sta Regist	ate rar	31. Date filed (Month, Day Year) 32. Registrar's Signature	,									

			1 - For State of Maryland / Depar Registrar Certification	tment of Health and Menificate of Death	tal Hygiene	42961
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month Day Year	3. Time of Death
3	/Media		BEULAH AUDREY BRATTEN	th City Tarana and analysis of Baselin	12 27 2004	0638 M
1	Examir	er		4b. City, Town, or Location of Death	4c. County of Deat	
	Comment			If Under 1 Year If Under 24 Hrs. 8. D	Date of Birth 9. Birth	hplace (State or Foreign
	Funeral Director		217-44-1972 1 M 2 M F 82 Yrs.	Months Days Hours Min.	Month, Oay, Year) CC. 22, 1922 Mar	yland
	9		Usual Residence of Decedent			1011-11-01-11-1
	anylar show	2	10a. State 10b. County 10c. City, Town or Loca			10d. Inside City Limits 11 Yes 2 □ No
	286-f	Director	Maryland Worcester Pocomo	oke City 10f. Zip Code	10g. Citizen of What Co	
	with t		401 Linden Avenue	21851	USA	on y
	leath	Funeral		as Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Ricar		nican Indian,
(0	ufter o	표	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No			e, etc.
<u>ğ</u>	72 hours after death with the Maryland natural", or Items 23e or 28e-f show Iteal Examiner must be notified at	ρ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 21/21 No Specify:	Specify: F	Black
21215-0036	I within 72 hours after death with the Marylan piene. Then "naturat", or items 23a or 28e-f show the Medical Examinating at	Completed	(Specify only highest grade completed) (Give kir	nt's Usual Occupation and of work done during most of working	16b. Kind of Business	Industry
121	within ene. then "	ldm	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired)	Dome	etic
	filed v I Hygie other I	e Co	5th laborer 17. Father's Name (First, Middle, Last)		st, Middle, Maiden Surname)	3610
an	e d la b	To Be	Lawrence Bratten, Sr.	Pearline	Finney	
Maryland	2 should be and Menta is marked eumetic ev	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rural Roll	ute Number, City or Town, State, 2	Zip Code)
	127 E		Elder Edward Bratten/brother 6812 F	orest Lane Road - S	now Hill, Maryla	nd 21863
ore	00-		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State	ion (Name of Date tory or other place)	20c. Location - City or	Town, State
Ĕ	Pages ment of t ent: If its		`4 □Donation 5 □Other (Specify) Coolspring			
Baltimore,	permit. Pag Department Importent: i any injury o once.		7 77 /4 / 1 :: / /	Name and Address of Facility 1213 J	*	•
	707 e 0		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter	LEY MEMORIAL CH		21801 Approximate
			shock, or heart failure. List only one cause on each line.		phatory arrest,	Interval Between Onset and Death
2	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	D		1
	Examiner					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	cuted nd ransii	Examine	that initiated events c.			
, 0,	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):			
8760,	ate he	Physician/Medical	d			
9 X	eath certifica attending pl	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	livery
Вох	atten atten	clar		ctopic pregnancy Other (specify)	Month	Day Year
P.O.	t the de by the tached	hysl	9 Unknown			
ω, σ	es that igned b	by P	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tobacco use contribute to	
ord	v require been siç should b		CVA		1 Yes 2 No 3 P	obably 4 Dinknown
Records,	e law re has be	Completed	CHF		autopsy prior to	utopsy findings available completion of cause of
= B		Con	HTW		performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes	2 □ No
Vital	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Ch		
of	Phys this ral di	: To	1 ☐ es 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ EN/Outpatient 27. Manner of Death 1 ☐ Matural 5 ☐ Pending (Month, Day Year) 1 ☐ Matural 5 ☐ Pending (Month, Day Year)	3 DOA 4 INdising Home	5 ☐ Residence 6 ☐ Other (Spe Describe how injury occurred	cify)
	Attending I r death. ector: After by the funer	tlor	1 (Month, Day Year) Injury 2 Accident investigation	Work? M 1 Yes 2 No		
Division	f or Attendi after death. Director: A in by the fu	Ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree	it, factory, office 28f. I	Location (Street and Number or R. City or Town, State)	ural Route Number,
ā	in Sire	Certification:	4 Homicide Building, etc. (Specify)			
	To the Hospitet or At within 24 hours after d To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the best of my knowledge,			
	To th To th comp	Ě	29b. Signature and title of certifie	29c. License number	29d. Date signed (Mont	h, Day, Year)
	63		> Cama	H50497	1/3/05	
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	H50497 55. SMISBURY	1 mo	
	1		31. Date filed (Month, Day, Year) 32. Pagistrar's Signature	21. SAUSON	, ,, -	
	Sta Regist		31. Date filed (Month, Day, Year) JAN 0 5 2005 JAN 0 5 2005	ale		

		•	For State Registrar	State o	f Maryland	l / Depa	artment of I tificate of	lealth an <i>Death</i>	d Mental Hy	giene Reg. No		42962
	1:	4	Decedent's Name (First, Middle	e, Last)					2. Date of Do	eath Da	y Year	3. Time of Death
	Physicia //Medic		Lillie M.	Bell					Decemb			2250 M
	Examin		4a. Facility Name (If not institution		n <i>ber)</i>		4b. City, Town,	or Location of D	eath	4c	. County of Deat	h
ı,			Montgomery	General H	ospital			01ney			Mont	gomery
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. Ia	st birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Bi Vin. (Month, D	rth	9. Birt	hplace (State or Foreign
	Director		289-30-1793	1□M 2 X F	71	Yrs.	Months	riours	June 2	25, 1	.933 F	lorida
	P .		Usual Residence of Decedent		10- 01-	T						and leader Obstitute
	show	_	10a. State 10b. County		Toc. City,	Town or Lo	cation					10d. Inside City Limits 1 □XYes 2 □ No
	9a-f	cto	Maryland Princ	e George'	s			ashingt	on			
	ith th	Director	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Co	untry?
	23a		1712 Dauph					20744				d States
	r de	Funerai	11. Marital Status	Armed Fo		. 13.	Was Decedent of I f Yes, specify Cub	Hispanic Origin an, Mexican, P	? (Specify Yes or No Tuerto Rican, etc.)	0-	14. Race - Ame Black, White	e, etc.
36	or It	by Fi	1 Never Married 2 Marr	If Yes, Giv	'e -		Yes 20 No	Specify:			Specify:	rican
Ö	ural',	q p	3 Widowed 4 Divorced		ates:	10- P				1 405 16		erican
5	"nat	Completed	(Specify only highe	t's Education st grade completed)		(Give	lent's Usual Occu kind of work done DO NOT use retire	during most of	working	100. K	(ind of Business/	industry
12	withly ane. Ithan	m d	Elementary/Secondary (0-12)	College (1	-4or 5+)	,,,,,,		_			Corror	
7	Hygie Hygie ther nt.	e Co	17. Father's Name (First, Middle,	10				cher 18. Mother's	Name (First, Middle	, Maiden	Gover	iment_
au	od o	00	, , ,	n Barron							llen	
Maryland 21215-0036	hould d Me mark matic	2	19a. Informant's Name/Relations			19b. Mailir	a Address (Stree	l tand Number o	r Rural Route Numb	-		Zip Code)
Ma	d 2 s th an th an trau		Leroy C. Bell		on				Drive, Co	-		
بة	1 an Heal em 2		20a. Method of Disposition	., 01.	20b. Pla	ice of Dispo	sition (Name of	1	Date		ocation - City or	
altimore,	nt of nt of t: # It		1 Burial 2 Cremation		State		natory or other pla	1	1 /7 /2005		A = 1 - = = +	~~ \\\
를	it. P.		* 4 □ Donation 5 □ Other (S		Arli				1/7/2005 Stewart F		Arlingt	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event. The Medical Examinar must be notified at once.		I m li i i T	Tours and	111				I., N.E. V			0019
	*		23a Part 1 Enter the disease, or	compli ations that c	ause the death.	Do not ent					, 10 2	Approximate
	in the second		23a. Part1. Enter the disease, or shoot, if heart failure. List Immediate Couse (Final				, , , , , , , , , , , , , , , , , , , ,	31				Interval Between Onset and Death
	Physician /Medical		disease o condition resulting in that	a.	pticemia							Days
Ľ	Examiner				or as a conseque							Months
į.	A	-	Sequentially list conditions, if any, leading to immediate	D	ng Cance							Honens
	ted	Examiner	cause. Enter Underlying Cause (Ulsass of Injury) that initiated events	<								
	xecu and	хаг	that initiated events resulting in death) Last	c	or as a conseque	ence of):						
8760,	icate be executed physician and s the burial-transit	al										
687	icate phys s the	edical		0.								
	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	M	IF FEMALE: 23b. Was decedent pregnant		come of pregnan						23d. Date of deli	ivery
Вох	leath atter	Physician/M	in the past 12 months?		irth 2 ☐ Fetal o ant at time of dea		lEctopic pregnanc Other (specify) _	У			Month	Day Year
o.	the d	ysi	9 Unknown	9□ Unkno	own							
<u>α</u>	that	by Pi	Part II. Other significant condition	ons contributing to de	eath but not result	ting in the u	nderlying cause gr	ven in Part I.	23e. Did	tobacco i	use contribute to	the cause of death?
ds	n signe	q p							10	Yes 2	□ No 3 XPr	obably 4 Unknown
Records,	w requir been si should	Completed							24a. Was		24b. Were au	topsy findings available
\mathbb{R}^{e}	The lav	шc								ormed?	death?	completion of cause of
Vital			25. Was case referred to medica	1				26 Place of	1 ☐ Yes	2 No	1 🗌 Yes	25140
		o Be	examiner? 1 ☐ Yes 2 No		npatient 2 E	R/Outpatien	t 3 DOA Ot	hor	ng Home 5 ☐ Res		6 ∏Other (Spec	cify)
o		-	27. Manner of Death	28a. Date	of Injury 2	28b. Time of	28c. Inju	ry at	28d. Describe			ny)
on	ding F th. After funer	tior	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	ig .	h, Day Year)	Injury	Wo M 1 □	rk?]Yes 2∐No				
Division	l or Attendi after death Director; A	fice	3 ☐ Suicide 6 ☐ Could	ined 288. Place	of Injury - At hon	ne, farm, str	eet, factory, office		28f. Location	Street an	d Number or Ru	ral Route Number,
\leq	after after Direct	Certification:	4 Homicide determ	buildi	ng, etc." (Specify)				City or To	wn, State	3)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director; Afte completely filled in by the fune		29a. Certifier Certifyir	ig Physician: To the Examiner: On the ba	best of my know	ledge, death	occurred at the ti	me, date and p	ace, and due to the	cause(s)	and manner as	stated.
	n 24 n 24 ne Fu	edical	(Check only 2 Medical one)	examiner: On the ba	asis of examination ner stated.	on and/or in	estigation, in my	opinion, death o	occurred at the time,	date and	place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of pertifie	r	_	\	29c. Licen	se number		29d. Da	te signed (Monti	n, Day, Year)
1			D L LAC	Lake	1 ers	1	91	453	91	De	°C 3	1. 2004
	(10)	1	30. Name and a sess of person	who completed caus				ULIK	NIWO	SJ	min .	/
	0		2401 RE	172c/t	BLUC		NTE IC		OULVILL	€, (תח בי	20850
											-	0 -
¢.	Sta	te	JAN 05 2		egistrar's Signatu	ite						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Julia Doris Brown 27 Dec. 2004 23:28 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical Centet Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ☐ M 2 ☐ XF Yrs. 264-76-9499 74 Feb. Director Peru Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Exendent must be notified at 1 ☐ Yes 2\OXNo Director Virginia | Prince William Dumfries 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 17522 Isle Royale Terrace 22026 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Maryland 21215-0036 1X Yes 2□ No Specify: Peruvian Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Dental Technician Dr. Kevin Smith, DDS oand 2 should be filk of Health and Mental Hyg. tem 27 is mark. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luis E. Torrico Ana Lly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 17522 Isle Royale Ter. Dumfries, Virginia 22026 Mr. Ronald W. Brown - son Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ö 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Everly Crematory 12-30-2004 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Everly-Wheatley Funeral Home permit. 1500 W. Braddock Rd. Alexandria, VA 22302 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis Priysician disease or condition resulting in death) /Medical Due lo (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No ó 9 Unknown 9 ☐ Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has page 2 certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 2 1 Tyes this 28a. Date of Injury (Month, Day Year) in by the funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: After To the Hospital or Attending 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide pellij hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 15807 Dec 27 , 2004 who completed cause of death (Item 23a) (Type, Print) 30. Name and a dress of person Bean

Registrar DHMH 17 Rev 1/2001

State

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JAN 04 2005

31. Date filed (Month, Day, Year)

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University of Maryland Medical Center-Baltimore, MD

			For 1 State			i / Depa	artment of H	lealth an	d Mental Hy	_	04	42964				
ine	-	_	Registrar 1 – 7 – 05 Amend # 1. Decedent's Name (First, Middle, Las		cr	Cer	inicale of t	Dealii	2. Date of De	Reg. No.		3. Time of Death				
н	Physicia				clene	Co	leman		Decemb	per 19,	2004	8:15p M				
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of D			y of Death	1				
	_xa	Ŭ	3926 Suitland Ro	ad #203			Suitlan	d		Princ	ce Geo	rges				
	Funeral		Social Security Number 6. S	ex 7. Ag □M 2QF	e (In yrs. la		If Under 1 Year Months Days	If Under 24 Hours		th Year) 2, 1925	9. Birthp	lace (State or Foreign try) ngton, KY				
	Director		579-32-3785	- W 2 X	79	Yrs.			June 1	.2,1925	Lexi	ngton,KY				
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits				
	Mary -f sh	tor	Maryland Prince (George	Suit	1and						XXYes 2 □ No				
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of						
	th wit	ai D	3926 Suitland Road	1 #203			20746			United	State	5				
	tams	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	'	3. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)		ce - Amend ack, White,					
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21215-0036	within 72 hours after death with the Maryland ene. than "netural", or itams 23a or 28a-f show the Madical Excining must be notilized at	ed k	15. Decedent's Ed			16a. Deced	dent's Usual Occup	ation		16b. Kind of E	Business/Inc	dustry				
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yla	Ment Ment arke	2	Herman Staley						e Williams			•				
Maryland	12 sh hand 7 ts m traum		19a. Informant's Name/Relationship (1				or Rural Route Numb							
	1 and Healt am 2 ther		Renee' Floyd/Daug 20a. Method of Disposition	nter	20b. Pla	ace of Dispo	sition (Name of	-1-2-	Date	lary Land 20c. Location		6 Apt 203				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or flams 23a or 28a-f show any injury or other traumatic avant, the Madical Examinat must be notified at ance.		1 🖾 Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify				natory or other plac lemorial		cember 23							
ij	artme artme ortan injur		21. Signature Funeral Service Lices		1	-		ss of Facility	004_ Robert G.	Magan	er Mai	cyland				
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	Pnysician		Immediate Cause (Final disease or condition	onset and Death												
	/Medical		resulting in death) a. Due to (or as a consequence of):													
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	ed sit	nine	Sequentially list conditions, the form and the cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseque	ence of It										
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9	tificat ig phy as th	Ψ								-						
Вох	requires that the death certifit een signed by the attending I nould be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnancy	,			ate of delive	ory Day Year				
Э. Е	e dea the at ned fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of de	ath 5□	Other (specify) _				OTILIT	Duy Faci				
P.O.	hat th	Phy	Part II. Other significant conditions of	ontributing to death b	out not resul	ltina in the u	nderlying cause giv	en in Part I.	23e. Did	obacco use cor	ntribute to th	ne cause of death?				
Records,	og De	d by	Alzheimers				,g 3		1 🗆	Yes 2□No	3 Prob	ably 4 Unknown				
Sor		Completed								an 24b.	Were auto	psy findings available				
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Ital		a	25. Was case referred to medical					26. Place of	1 ☐ Yes Death (Check only		1 🗆 Yes	2 10				
32	Physician: this certific ral director,	To B	examiner? 1 🔀 Yes 2 🗌 No	Hospital: 1 Inpati	ent 2 🗆 E	R/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursii	ng Home 5 Res	dence 6 🕉	her (Specif	At Scene				
n of	ng Ph fter th neral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	iry y Year)	28b. Time of Injury	Wor			how injury occu	rred					
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Division	or At ifter d Direct in by	Certification:	4 Homicide determined	286. Place of in	ju ry - At hor tc. (Specify)	me, farm, str)	eet, factory, office			wn, State)	ber or Hura	l Route Number,				
	Hospital or 4 hours afte Funaral Dir tely filled in	ai Ce	29a. Certifier 1 ☐ Certifying Ph	nysician: To the best	of my know	vledge, deatl	n occurred at the tir	ne, date and n	place, and due to the	cause(s) and m	ianner as si	ated.				
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director,	Medicai		niner: On the basis of and manner st	f examinati											
	To th within To th comp	Me	29b. Signature and title of certifier	. a A	0		29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)				
	1		> Zahim	lal A	e !		OCM	E		Decembe	er 28,	2004				
7/	(1)		30. Name and address of person who									1001				
4			ZABIALC				111 Penn	Street	Baltimore	e, Maryl	and 2	1201				
	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 7 200		rar's Signat	La	di)									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 2 Month a M **Physician** 4:50 31 2004 Frances Hunteman Cunningham /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot 8357 Church Neck Rd. st. Michaels If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 F 1-1-1945 220-46-5948 59 Long Island Director Usual Residence of Decedent NY with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County r then "naturel", or Items 23a or 28e-f show the Medical Exercises must be notified at Md Talbot St. Michaels 1 ☐ Yes X☐ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 8357 Church Neck Rd. 21663 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Item eny injury or other traumatic event, the Medical Examination. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Years Farmer Farming 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Frank B. Johnston Edna Harley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William Donald Cunningham 8357 Church Neck Rd., St. Michaels, Md21663 (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) San Domingo Farm 1-3-2005 St. Michaels, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility R. Carroll Hurley Funeral Home, PC 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of oring, such as cardiac or respiratory areas. I and Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CIRRITERS **Physician** -ANNEUS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine -transit death certificate be executed and Due to (or as a consequence of): burial-P.O. Box 68760 attending physician Physician/Medical as the l esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of deliven 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 2□ No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of of or Attending Patter death. 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funeral C completely filled in Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) d manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1/3/05

State Registrar Must

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert J. Patterson, MD. 800
31. Date filed (Month, Pay, Year)
JAN 0 3 2005

00057908

800 S. Talbot St., St. Michaels, Md.21663

			1- For Amend Items 25,27,27,26842	ıpıland / Depas Certi			ental Hygier	2004	42966
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day 2004	3. Time of Death 5:35 PM
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	e Maryland 8e-1 show	ctor	Usual Residence of Decedent 10a. State 10b. County Md. Worcester	10c. City, Town or Local Ocean Pi				1	1 lod. Inside City Limits
	th with th 23a or 24	Funeral Director	10e. Street and Number 2 Fleet Court		10f. Zip Code 21811		-	Ditizen of What Cour	itry?
036	ours after death with the Manylar ral", or iteme 23a or 28e-1 show Examinar must be notified at	ē	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes, Sive Year or Dates:	ver in U.S. 13. Walf Y	s Decedent of His es, specify Cuban Yes 2 No	panic Origin? (Spe , Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
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	tem 27 land 2 leem 27 la		19a. Informant's Name/Relationship (Type, Print) Salvatore J. Costa 20a. Method of Disposition 1 □ Burial 2♥ Cremation 3 □ Removal from State	2 F1	eet Ct. on (Name of ory or other place)	Ocean	Pines, A	or Town, State, Zip 1d. 2181 Location - City or To	1 own, State
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10 3/15. 10 3/15.	t the death certifice by the attending pt ached for use as tl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	2 ☐ Fetal death 3 ☐ Ec	topic pregnancy ther (specify)			23d. Date of delive Month	ory Day Year
2005 9 012 rds, P.O	luires that tl n signed by ild be detac	۵	Part II. Other significant conditions contributing to death but	t not resulting in the unde	orlying cause given	in Part I.	23e. Did tobacco	use contribute to the	e cause of death?
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\$ 50 JO	ding Physicien:). After this certific funeral director,	To Be	examiner? 1 Xyes 2 Hospital: 1 Impatient	nt 2 ER/Outpatient 28b. Time of	3 DOA Other:	4 I Nursing Hom		6 ☐Other (Specify	9
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Div	i Sirie		building, etc. Nursing	home		1.5	9715 Hea 1	and Number of Rura te) Berlin, thway Driv	ve,
	To the Hospital within 24 hours a To the Funerel I completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of e	examination and/or invest	tigation, in my opir	nion, death occurred	d at the time, date a	nd place, and due to	the cause(s)
64	V Vit		29b. Signature and title of certifier Musture Life Particular of the control of	n, No	29c. License r	06795	_	ate signed (Month, 1 15-04	
C_{\cdot}	H.10		30. Name and address of person who completed cause of dea	eay Far	IWICK.	INE OF	B, DE	19944	+
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ROBERT	Division

		Please Type or Print in Black In			_	_	10000
	1	1 - State Registrar AMEND ITEM #2 PER DVR G840 2/R				2 U U 4	42967
Physicia		Decedent's Name (First, Middle, Last)			2. Date of Death Month JANUARY	Day 2005	3. Time of Death
/Medica	al -	Robert Edward Dean 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or I		JANUAKI	8 2004 4c. County of Death	6:34p
Examine	er	St. Mary's Hospital	Leonar			St. Mary	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 ☑ M 2 ☐ F 5.9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Birth Cou	place (State or Foreign ntry)
Director		217-46-9052 58 Yrs. Usual Residence of Decedent			Aug. 21	, 1946 Was	hington,DC
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after deatl	iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of His If Yes, specify Cuban			14. Race - Ameri Black, White	ican Indian,
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filed v Hygie other t	င္ပ	12 – Dis 17. Father's Name (First, Middle, Last)	abled	18. Mother's Name	(First, Middle, Ma		
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2 sho and ? is ma						City or Town, State, Zi	
1 and Health em 27		20a Method of Disposition 20b. Place of Dispo	sition (Name of			ie, Marylar Oc. Location - City or T	
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permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa once.		21. Signature of Funeral Service Licensee	2. Name and Address	of FacilityBrin	sfield-E	chols F.H.	, P.A.
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or Attending Physician: Ifter death. Director: After this certifica in by the funeral director. I	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	al Ce	29a. Certifier 112 Certifying Physician: To the best of my knowledge, deat	th occurred at the time	e, date and place,	and due to the cau	use(s) and manner as	stated.
he Hos n 24 h he Fur pletely	edical	(Check only a Medical Examiner: On the basis of examination and/or in and manner stated.			ed at the time, dat	te and place, and due	to the cause(s)
To the within 2 To the complete	Z	29b. Signature and title prenifier	29c. License		29	d. Date signed (Month	Day, Year)
		20 November of April (from 22a) Trupo	D60	888		01/10/0	15.
		30. Name and address of preser who completed cause of death (Item 23a) (Type, RAKHI KRISHNAN SHAH ASSOC HOLLYW		20636			
Sta		31. Date filed (Month, Day, Year) 1 2005 32. Registrar's Signature	Roselle				
Registr	ar	JAMES TO A					

State of Maryland / Department of Health and Mental Hygiene 2004 42968 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 31, 2004 Robert Lee Downs December 10:42 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Min. | April 1, 1944 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**™**M 2□F 60 220-42-5421 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 XNo Directo Maryland Frederick Frederick 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 10540 Bethel Road 21702 USA death 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Heavy Equipment Operator Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked of any injury or other traumatic ever Kenneth R. Downs Anna G. Eyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10540 Bethel Road, Sherry Ann Downs/Wife Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/5/2005 Lewistown Cemetery Lewistown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home, 2PA 1621 Opossumtown Pike Frederick, MD, 21702 oustre Part1. Enter the dise se or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. Vist only one cause on each limit. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Onset and De Years Arteriosclerotic Cardiovascular Disease **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transif Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 Other (specify) the a detached á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 TUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No page 1 Yes 1 Yes 2 🗀 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certification: To Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral c 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D35164 January 3, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD_ 15) West 7th Street, Frederick, MD 21701 Andrew Zarick, Jr. 31. Date filed (Month, JA: Near) 32. Registrar's Signature State 30 Registrar

		1	For State	State of	Maryland		rtment of He				ene 0	04	429	69
		1	Registrar Decedent's Name (First, Middle, Last)						2. Da	ate of Death		.,	3. Time of	Death
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Fun	oral	5	. Social Security Number 6. Sex		. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Da Min. (A	ate of Birth fonth, Day, Y	(ear)	9. Birth	place (State or	r Foreign
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ary s me	mma		19a. Informant's Name/Relationship (T)	rpe, Print)			ng Address (Street							
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im Pag ment	ury		4 □ Donation 5 □ Other (Specify,				tan Crema						Virgin	nia
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m %05	8 0		my	my			E. Deer					g, MD	20877 Approximat	Α
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	s ce direc	To	examiner? 1 ☐ Yes 2 🌠 No	Hospital: 1 🗆 li	npatient 2 🗆 I	ER/Outpatie	nt 3□ DOA Oth	ner: 4 🗆 N	Nursing Home				Resid	lence
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Vision Attending	tor: Al the fu	atic	2 Accident investigation					Yes 2		Lacation (Ct	mat and Al	umbor or O	ural Pauta Mura	nhor
Division of or Attending	Director: In by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	289. Place	of Injury - At ho ng, etc. <i>(Specif</i> y	me, farm, s ')	treet, factory, office		281.	City or Town	reet and iv i, State)	umber or Au	ıral Route Nun	nber,
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·			30. Name and address of person who				ille Pike	. #C	100 Ro	ckvil	1e. M	arv1ai	nd 2085	52
	64	ate	Alpana Goswami 31. Date filed (Month, Day, Year)	32.	egistrar's Signa	ture	Lite IIK		-00 KC		, 11			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** DRENETTA WATTS GRIFFIN 10:30 A M 23. 2004 Dec. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5129 TEMPLE HILL ROAD Prince George's Temple Hill If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 51 Yrs Director Nov.17,1953 Wash.,D.C. 578-74-1821 Usual Residence of Decedent works ! 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "naturel", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Montgomery Potomac 10e. Street and Number 7935 10f. Zip Code 10g. Citizen of What Country? Foxcrest Court 20854 death v U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify. **Black** 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked ofth any injury or other treumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edren L. Watts Jaisy L Jones Watts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Griffin/husband 7935 Foxcrest Court Potomac, Md. 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Warial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Resurrection Cemetery 12/31/04 Clinton, Maryland 22. Name and Address of Facility
Frazier's Funeral Home, Inc. 21. Signature of Funeral Service Licensee M101320 Maun Watts 389 R.I. Ave., N.W. Wash., DC 20001 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** enths Corumn /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and I-transit that the death certificate be executed physician ar Due to (or as a consequence of) Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No į Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 9 The law requires been sig 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No autopsy performed? page certificate 1 ☐ Yes Division of Vital 2**X** No Hospital or Attending Physicien: After this certific funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Management (Specify) Sister s 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Tes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Injury 1X Natural 5 Pending death. 1 Tes 2 No М investigation 2 Accident the Director 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospius within 24 hours after d
To the Funeral Direc þ 4 Homicide 🖎 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 04 30. Name and address of person who comp ed cause of death (Item 23a) (Type, Print) 11701 Livingston Road Suite 101 Fort Washington, Md. 20744 Frank Ryan, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State JAN 0 5 2005 Registrar

		-	For State Registrar	State of Marylan		rtment of H				ienę.	2004	429	71
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	Funeral Director			7. Age (In yrs.	Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day)	1945	9. Birth Con Was	nplace (State o untry) ningtor	r Foreign
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside Ci	ty Limits
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	ems ems	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Or	igin? (Spe	cify Yes or No-	1	4. Race - Ame Black, White		
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene ad other than "natural", or items 23a or 28a-f show do than than "natural", or items 23a or 28a-f show event, the Medical Examinar must be ricitied at event, the Medical Examinar must be ricitied at	by	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		□Yes 21XNo	Specify				Specify: Bl		
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Baltimore,	permit, Page Department of Important: If any injury or		21. Signatur of Fineral Service Licer	Guerran	<i>r</i> : 1	. Name and Addres					l Servi 753	ces	
	3 4		23a. Part1 Enter the disease, or com shock or heart failure. List only	plications that caused the deat	h. Do not ent	er the mode of dyin	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Bet	ween
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a		e Co	25. Was case referred to medical				00 81-	(0 4	1 ☐ Yes	2 N 0	1 ☐ Yes	2 No	
Vital		0 8	examiner?	Hospital: 1 Inpatient 2	ER/Outpatier	it 3□ DOA Oth			(Check only or ne 5 ☐ Resid		Other /Sne	260	
of	ding Phys	n:T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		y at		28d. Describe h			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
io	teath, tor: Aft the fun	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigatio		Injury		Yes 2	No					
Division	ter de	Certification:	3 Suicide 6 Could not be determined		ome, farm, str fy)	eet, factory, office		4	28f. Location (S. City or Town			ıral Route Num	ber,
0	urs af urs af ural D				45-25-7								
	To the Hospital or Atlanding within 24 hours atter death, To the Funaral Director: After completely filled in by the fune.	Medical	(Check only 2 Medical Exam	nysician: To the best of my kno niner: On the basis of examina and manner stated.	ation and/or in	vestigation in my o	minion de	ath occurr	ed at the time, d	ate and	nlace and due	to the cause(s	;)
	To th Within To th	Me	29b. Signature and title of certifier			29c. Licens	e number		2	9d. Date	e signed (Monti	h, Day, Year)	
	^		Mehan L	Loisier, MIS		DO)Sn	514	(,)	an	VACA !	2.200	15
1	R ~		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type,	Print)	U			JU11	-41 13.		
\vee	1 (5)		MEHRO MASTER	C,MB 6570 K	enilu	MAN G	we.	Sur	le 2100	1 6	iverdo	LE MB	20933
	St Regist	ate rar	30. Name and address of person who MEHRU MASTER 31. Date filed (Month, Day, Year) JAN 05 200	2. Registrar's Sign	ature	Le le							

			, FOI	artment of Health and Me	ntal Hygien	7 HHL 62972
	Physici		Decedent's Name (First, Middle, Last) PAUL C. GARLAND	2. D	Date of Death	30, 2004 3:45A. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring	4	C. County of Death Montgomery
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 408–36–3809 1. M 2 F 80 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. S	Date of Birth (Month, Day, Yea EPT. 1, 1	9. Birthplace (State or Foreign South Carolina
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L Maryland Prince George's Beltsvil			10d. Inside City Limits 1 ☐ Yes 2X No
	sa or 28a-	Funeral Director	10e. Street and Number 4902 Brandon Lane	10f. Zip Code 20705	1 -	Citizen of What Country? nited states
036	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. Is marked other than "natural", or Itams 23a or 28a-f show aumatic event, the Madical Examinant aunt be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 12. Yes 2 No If Yes, Give Year or Dates: 1946—1948	Was Decedent of Hispanic Origin? (Specifil Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	i within 72 hou iene. r than "nature ine Medical E	Completed	(Specify only highest and completed) (Give	edent's Usual Occupation a kind of work done during most of working DO NOT use retired) Cher		Kind of Business/Industry epartment of ARMY
Maryland 2121		0	17. Father's Name (First, Middle, Last) Earl M. Garland	18. Mother's Name (F Birdie N.	Wolfe Walde	ən Sumame)
	and 2 should leath and Men n 27 is marka		Mildred T. Garland -wife 4902	ing Address (Street and Number or Rural R Brandon Lane Beltsv	ville, Ma	ror Town, State, Zip Code) ryland 20705
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked any injury or other traumatic a once.		20a. Method of Disposition 1 □ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	osition (Name of ematory or other place) Veterans Cemetery 1		Location - City or Town, State Cheltenham, Maryland
Balt	permit. Page Department of Important: If any injury of		Harald VID agained 44	¹² Nameand Address of Facility Thalo V. Borgwardt F 100 Powder Mill Road	Beltsvi.	lle, Maryland 20705
	rnysician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a		espiratory arrest,	Approximate Interval Between Onset and Death Months
8760,	sate be executed shows it is a prize transit the burial-transit and	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
.O. Box 68	death certific e attending p id for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
s, D	tuires that the din signed by the lad be detached		Part II. Other significant conditions contributing to death but not resulting in the Metastatic Cancer; Anemia	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Vital Record	: The law requires that the cate has been signed by the page 2 should be detache	Completed by			24a. Was an autopsy performed?	
Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2♥ No Hospital: 1 ▼ Inpatient 2 ☐ ER/Outpatie	26. Place of Death (Control 3 DOA Other: 4 Nursing Home		6 ☐Other (Specify)
Division of	ding h. After funer	Certification; 7	27. Manner of Death 1 X Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at 28c. Work? M 1 Yes 2 No	d. Describe how inj	
Dixi	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.		4 Homicide determined 288. Place of Injury - At nome, farm, si building, etc. (Specify)		City or Town, Sta	HERRITA TO THE STATE OF THE STA
	ha Hospital in 24 hours a ha Funaral I pletely filled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.			
•	To tha within 2 To tha complet	Z	29b. Signature and title of certifier Water Wat	29c. License number D32332		Date signed (Month, Day, Year) uary 1, 2005
	*		30. Name and address of person who completed cause of death (Item 23a) (Type SK Gupta, M.D. 9801 Georgia Avenue,		Marylan	d 20902
	Sta Regista		31. Date filed (Month, Day, Year) JAN 0 4 2005 32. Pigistrar's Signature	puli		

	Physici	an	1 - For Registre MEND#18perINF1 1. Decedent's Name (First, Middle, Las	ot)	081	tificate of L	Jealii	2. Date of Dea Month	Day	Year	3. Time of Death
	/Medio	al	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of De			2, 2004	11:30P M
Н	LAGIIII		Casey House			Rockvil	le.		Mo	ntgomer	7
	Funeral Director		5. Social Security Number 6. S 171–30–2327	ex 7. Age (In yrs. last 66	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		, Year)	9. Birthpla	ace (State or Foreign ry) Sylvania
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Lo	cation				10	d. Inside City Limits
	the Man 28a-f sh notition	Director	Maryland Montgom	ery Sil	ver S	pring 10f. Zip Code			IOn Citiza	n of What Count	1 ☐ Yes 2 📉 No
	h with		12515 Eastbourne	Dr		20904			US.		ıy:
020	ould be filed within 72 hours after death with the Maryland Meral Hygiene. arked other than "natural", or Items 23a or 28a-f show arte ovent, the Medical Evalution main the notified at	by Funeral	11. Marital Status 1 Never Married A Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 147 Yes 2 No 1f Yes, Give Year or Dates: 1956			spanic Origin? n, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	14.	Race - America Black, White, e pecify: White	tc.
<u> </u>	nin 72 ho In "natur Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	fucation	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	uring most of w	vorking	16b. Kind	of Business/Indi	
7	ed with	Com		4		_Pharmaci	st		Reta	<u>i1</u>	
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Is marked other than aumatic evant, tra M	To Be	17. Father's Name (First, Middle, Last) Louis Goodman				Cathe	^{ame (First, Middle,} Erine Sche obtainahl		imame)	
2	and and sm		19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street a	nd Number or	Rural Route Numbe	r, City or T	own, State, Zip (Code)
a)	1 and 2 Health am 27 I		Glenda Goodman/Wi	20b. Plac	e of Dispo	sition (Name of		Silver S		, MD 209	
baitimore,	permit. Pages I Department of H Important: If Its any injury or ot		V☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State cem	etery, cren	natory or other place		Dec 24, 20			
<u>=</u>	partm portar y injui		21. Signature of Funeral Service Licen		22	. Name and Addres	s of Facility H	ines-Rinal	ldi F	uneral H	lome
מ	e e E e e		· alang	Donnell							MD 20904
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events	a. End S Due to (or as a consequer b. Due to (or as a consequer	nce of):	Metastati	c Sarco	oma			nterval Batween Onset and Death
8/00,	icate be executed physician and s the burial-transit	icai	resulting in death) Last	Due to (or as a consequer	nce of):						
O. BOX 6	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of deat	eath 3	Ectopic pregnancy Other (specify)			230	d. Date of deliven Month E	y Day Year
rds, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but not resulting	ng in the u	nderlying cause give	n in Part I.		bacco use es 2 📈		cause of death?
al Records,	i: The law re icate has bei	Completed						24a. Was a autop: perfor 1 \(\text{ Yes} \)	in 2 sy med? 2 X No		sy findings available pletion of cause of
VII	siclan: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		Othe		eath (Check only or			77 4
DIVISION OF	Attending Physician: It death, ector: After this certification is the funeral director.	ition: To	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Outpatien Bb. Time of Injury	28c. Injury Work	at ? 'es 2 □ No	Home 5 Resid			Hospice
DIVIS	or Dir	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Town		lumber or Rural	Route Number,
	To the Hospital or Ati within 24 hours after d To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one)	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death and/or in	occurred at the tim vestigation, in my op	e, date and pla inion, death oc	ce, and due to the courred at the time, d	ause(s) an ate and pla	id manner as sta ace, and due to t	ted. he cause(s)
	To the within 2 To the complet	Me	29b. Signature and tale of certifier	1//		29c. License	number	2	9d. Date s	igned (Month, D.	ay, Year)
			CHOUNT			0	1121	8	12	123/0	74
	0										

			For State Registrar	State of Marylar	nd / Depa	artment of Heartificate of De	alth and Me	ntal Hygie		42974
			Decedent's Name (First, Middle, La	st)				. Date of Death		3. Time of Death
	Physicia						D	Month	Day Year	01:39P ^M
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or Lo		ecember	27, 2004 4c. County of Dea	
		er				Rocky			Montgo	
	Funeral		Rockville Nursing 5. Social Security Number 6. S		last birthday)	If Under 1 Year If		. Date of Birth (Month, Day, Y		thplace (State or Foreign
	Director			I□M 2 X IF 89	Yrs.	Months Days		(Month, Day, Y- 2/25/19]	_	shington,DC
			Usual Residence of Decedent					4/43/13	L) wa	SHITHEROH, DC
	ylan how		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	a-f s	cto	Maryland Montgome	rv R	ockvil	le				1 ☐ Yes 2 ☐ No X
	or 28	Directo	Maryland Montgome: 10e. Street and Number	- 9		10f. Zip Code		10g	. Citizen of What C	ountry?
	death with the Maryland ims 23e or 28e-f show		303 Adclare Road	1		2085	50	Ţ	J.S.A.	
	ems	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, I	anic Origin? (Speci Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Am- Black, Whi	
õ	or it	F	1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		_	Specify:		Specify:	
9500-61212	ural',	d by	3 Widowed 4 □ Divorced							white
ភ្ន	72 h	Completed	15. Decedent's E (Specify only highest gro	ducation ade <i>completed)</i>	(Give	dent's Usual Occupatio kind of work done duri DO NOT use retired)	n ing most of working	16	b. Kind of Business	Vindustry
7	hen.	m D	Elementary/Secondary (0-12)	College (1-4or 5+)					_	
N	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or items 23e or 28e-f show event, the Madical Examinar man be notified at	ပိ	12 17. Father's Name (First, Middle, Last)		Housewife	I. Mother's Name (First Middle Ma	Domest	10
ğ	ntal hed o	Be		_						
Maryland	d Me d Me nark	ပ	Thomas William 19a. Informant's Name/Relationship (10h Mailir	ng Address (Street and		tta Kahl		Zin Codol
Z Z	permit. Pages 1 and 2 should be to Department of Health and Mental Himportant: if item 27 Ia marked of any injury or other traumatic even once.		Karl F. Gruel Jr	**	100	Morningwood			-	2.p C006)
ტ —	1 and Healt em 2 ther		20a. Method of Disposition			9	Dat Dat	-	c. Location - City or	Town, State
Baitimore,	200 = 500 E = 500		1 1 Burial 2 □ Cremation 3 5	Suemoval mont State		esition (Name of matory or other place)	0.1.400			
	t. Parturant		*4 Donation 5 □ Other (Speci	1		n Nat. Cem.			Lexandria	, VA
g	Depa Mpo mpo any in		21. Signature of Funeral Service Lice	nsee		2. Name and Address of				ng, MD 20904
	202.0		23a. Part1. Enter the disease, or con	a plientions that soused the dea		1800 New Ha				Approximate
п			shock, or heart failure. List only	one cause on each line.	IIII. DO NOL GIN	er the mode of dying, s	Sucil as caldiac of i	espiratory arrest	1	Interval Between Onset and Death
	Prysician		Immediate Cause (Final disease or condition resulting in death)			siv e Heart	Disease			
П	/Medical Examiner			Due to (or as a conse	5					
Н		<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse		ib r illation	1			
	ted nsit	i i	Cause (Disease or injury			acculom Acc	ddant			
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a conse		ascular Acc	Luent			
8760	certificate be executed ding physician and use as the burial-transit	icai E		al						
687	ficate I physics the b			0.						
×	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr	nancy				23d. Date of de	liverv
m	death e atten ad for u	ciai	in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)			Month	Day Year
o	by the de	ysi	9 Unknown	9□ Unknown						
<u>. </u>	The law requires that the tite has been signed by the bage 2 should be detache	by PI	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause given i	in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
rds,	quires n sign							1 🗆 Yes	2 No 3 P	robabiy 4 🔀 Unknown
Record	w require been si should b	Completed						24a. Was an	24b. Were a	utopsy findings available
Re	The lavate has	l E						autopsy performe	prior to	completion of cause of
Vital		e C	25. Was case referred to medical			21	6. Place of Death (No 1 ☐ Ye	s 2 No
5	Physiclan: r this certificatal director, I	0 8	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatie				ce 6 ☐ Other (Spe	2016.1
Division of	Phy ar this aral d	 -	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Injury at		d. Describe how		ecnyy
on	tending leath. tor: After the funer	tio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work? M 1 ☐ Yes	s 2 🗆 No			
VIS.	or Attending after death. Director: After in by the fune	ifice	3 Suicide 6 Could not I	288. Place of Injury - At I		reet, factory, office	28	f. Location (Stre	et and Number or F	tural Route Number,
á	in Sta	Certification;	4 Homicide	building, etc. (Spec	ify)			City or Town,	State)	
	spite hours inera y fille		29a. Certifier 1 Certifying P	hysician: To the best of my kr	lowledge, deat	h occurred at the time,	date and place, an	d due to the cau	se(s) and manner a	s stated.
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical Exa	miner: On the basis of examinand manner stated.	nation and/or in	vestigation, in my opini	ion, death occurred	at the time, date	and place, and du	e to the cause(s)
	To the within To the Comp	M	29b. Signature and title of certifier			29c. License n	umber	290	l. Date signed (Mon	th, Day, Year)
			1 Moma	o U. Pose	NU	D	47330		January	3, 2005
	3		30. Name and address of person who		ят 23a) (Туре,	Print)				
			Thomas V. Jo	seph, MD 50	W. Edm	onston Dr,	Rockvill	e, MD 2	0852	
	St	ate	31. Date filed (Month, Day, Year)	32. Redistrar's Sign	nature	harle				
	Regist	rar	JAN 04	2005 Blown	15 19					

				State of Marylan				•	_	m 1 1 2 m m m 271
			1 - For State Registrar	otato or marytan			of Death	_	Reg. No.	04 42975
		8	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath	3. Time of Death
	Physici /Medio		Reba Lee Gaar						er 30	2004 0055 ^M
}	Examin	er	4a. Facility Name (If not institution, give :	street and number)		4b. City, To	own, or Location of Dea	ath	4c. Coun	ity of Death
			Anne Arundel Medical Security Number 6. Security Nu		last hirthday)	Ann	apolis Year If Under 24 Hi	s. 8. Date of Bird		e Arundel
	Funeral Director		1]M 2√2F	Yrs.	Months [Days Hours Mi		y, Year)	9. Birthplace (State or Foreign Country)
	ъ		408-32-1115 Usual Residence of Decedent	81		l		Dail. J	1923	Tennessee
	anylar show	'n	10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the M	ecto	Maryland Anne Aru	ndel 1	Annapo	lis 10f. Zip C	ada		10a Citizan a	f What Country?
	3a or	Funeral Director		ri ro						_
	death ms 2	nera	509 Forest Hill D	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Deceder	nt of Hispanic Origin? Cuban, Mexican, Pue	Specify Yes or No		d States ace - American Indian,
9	or ite		1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	1	1 ☐ Yes 2 ☐		into rican, etc.)	Spec	lack, White, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28e-f show fre Me Jical Exacultar must be notified at	Completed by	3√ Widowed 4 Divorced	Year or Dates:						white
7	in 72 n "nai	piete	15. Decedent's Edu (Specify only highest grade	completed)	(Give	dent's Usual (kind of work DO NOT use	done during most of w	orking	165. Kind of	Business/Industry
272	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	h	omemak	er		OWD	homa
	al Hyg	BeC	17. Father's Name (First, Middle, Last)					ame (First, Middle,		
$\frac{1}{2}$	Ment Ment Markec	To	Brownlow Shelton	107			Minery			
Maryland	12 sh h and 7 ie m treum		19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (S	Street and Number or I	Rural Route Numbe	r, City or Town	n, State, Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examination in the notified at once.		Karen Kleis/ daugl	120b. P	lace of Dispo	4 Perc.	of	MD 2114	20c. Location	n - City or Town, State
<u>o</u> r	ages ant of nt: if if		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, crei					5.7255 (24)
Baltimore,	mit. Foorter		21. Signature of Funeral Service License		semont 22	Cemeta 2. Name and	ery Jan Address of Facility T	. 3, 2005	David	sonville, MD uneral Home, Inc.
m	Depa Impo any id		1 Dwit 1	omendu	1.	47 Duk	e of Glouc	ester St.	Annap	olis, MD 21401
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death ne cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Demeli	2					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	1 - 1	1			
		-i-	Sequentially list conditions,	Due to for its a consequ	uence of):	ruscy	celly	-		
	uted d ansit	Examiner	Sequentially list conditions, immodificates. Enter Underlying Cause (Disease or injury that initiated events	Seziele	<i>S</i>		,			
o,	be executed ician and burial-translt		resulting in death) Last	Due to (or as a consequ	uence of);					
8760	e ys	licai		1						
x 68	death certifica e attending ph d for use as th	/Mec	IF FEMALE:	3c. If yes, outcome of pregna	nev					
Вох	atten atten I for u	cian	in the past 2 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3[Ectopic preg				Pate of delivery fonth Day Year
O.	the d	hysi	1 ☐ Yes 2 No 9 ☐ Unknoyn	9□ Unknown			,,			
ď.	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	by Physician/Med	Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the u	nderlying cau	se given in Part I.	23e. Did to	bacco use cor	ntribute to the cause of death?
Records,	w require been sig	ted	yeual be	suly				1 🗆 \	es 2□No	3 □ Probably 4 ☐ Unknown
ec	a law r	Completed					· · · · · · · · · · · · · · · · · · ·	24a. Was autop	sy	. Were autopsy findings available prior to completion of cause of
E H									med? 2 No	death? 1 ☐ Yes 2 ☐ No
Vital		o Be	25. Was case referred to medical examiner?	lospital:			Other	eath (Check only o		
ō	ding Phys ih. After this funeral di		1 ☐ Yes 2 No ☐	28a. Date of Injury	ER/Outpatier 28b. Time of		. Injury at	Home 5 Resid		
<u>o</u>	Attending r death. sctor: After	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м	Work? 1 ☐ Yes 2 ☐ No			
Division	r Atte er der recto by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, c	office	28f. Location (S City or Tox		nber or Rural Route Number,
	Hospitel or 24 hours afte Funerei Dir tely filled in		1							
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only 2 Medical Examination)	sician: To the best of my knowner: On the basis of examinat	wledge, deatl tion and/or in	n occurred at vestigation, in	the time, date and place my opinion, death occ	ce, and due to the courred at the time, o	cause(s) and m date and place	nanner as stated. s, and due to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature/and title of certifier	and manner stated.		29c. L	icense number		29d. Date sign	ed (Month, Day, Year)
	⊢≯⊢ŏ		ANITA	IA Comme	Δ		X7028		12/20/	CV4
			30. Name and address of person who co	empleted cause of death (Item	23a) (Type,	Print)	3 / 000		159	~
			Dr. Aditya Chopi			nue Ar	napolis, N	Maryland	21401	
	Sta Registr	_	31. Date filed (Month, Day, Year) JAN 0 3 20	32. Figistrar's Signa	ture	6.0				
	riegisti	cat -			W /					

			1 - For State Registrar	State of Marylar		artment	of Health and of Death	Mental Hygi	ene g. No 2004	42976
I	Physici	an	Decedent's Name (First, Middle, Last) DECUMENT A MARRINA					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	RICHARD AUSTEN	HITCHCOCK		1 0't T		December	25 2004	6:00 P M
	Examin	er	4a. Facility Name (If not institution, give : Holy Cross Rehab		nter		own, or Location of Decomposed in the constitute of the constitute of the constitution	ath	4c. County of Death	
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.		If Under 1	Year If Under 24 Hi	s. 8. Date of Birth		nplace (State or Foreign
	Director		216.12.3014 1State Usual Residence of Decedent	M 2□F 82	Yrs.	Months	Days Hours Mi	8. Date of Birth (Month, Day, Oct. 29	, 1922 Mar	yland
	72 hours after death with the Maryland natural; or Itema 23a or 28a-f show lical Examinar must be notified at		10a. State 10b. County		ty, Town or Lo		-			10d. Inside City Limits
	Ne Ma	Funerai Director	Maryland Prince (eorge's La	angl e y					1 ⊠Yes 2 □ No
	with t	Dir	10e. Street and Number			10f. Zip C		10	g. Citizen of What Co	untry?
	ma 23	nera	1706 Langley Way	12. Was Decedent Ever in U	J.S. 13. \	207 Was Deceder	of Hispanic Origin? Cuban, Mexican, Pue	Specify Yes or No-	U.S.A.	ican Indian,
9	or ite	/ Fui	1 Never Married 2 Married	Armed Forces? 1 A Yes 2 No If Yes, Give T.T.T. T		lf Yes, specify 1 □ Yes 2 ☑		erto Rican, etc.)	Black, White	_
003	ural',	d by	3 ଔWidowed 4 □ Divorced	Year or Dates: WW 1	· <u> </u>					hite
21215-0036	in 72 in 72 in 12	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Deced (Give	dent's Usual (kind of work DO NOT use	Decupation done during most of w retired)	orking	6b. Kind of Business/I	
212	filed within Hygiene.	omo;	Elementary/Secondary (0-12) 8th	College (1-4or 5+)		nsmith			U.S. Gover	nment
nd	should be filed within 72 hours after death with the Marylan Id Mental Hygiene. marked other than "natural", or Itema 23a or 28a-f show marked other than "natural", or Itema 23a or 28a-f show matice event, its Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle, M	aiden Sumame)	
yla	2 should be f and Mental P is marked of raumatic eve	은	William Augustus					nna Miller		
Maryland	2 8 8 2	. 0	19a. Informant's Name/Relationship (Ty Madonna Hitchcoc						City or Town, State, Z	
ē,	s 1 and 2 (Health item 27 l	1	20a. Method of Disposition	20b. F	ZOO W Place of Dispo cemetery, cren	sition (Name	of	Date 2	e, Marylan Oc. Location - City or 1	d 21210 Fown, State
E	Pages nent of int: If it	1	1 ABurial 2 □ Cremation 3 □ F 1 4 □ Donation 5 □ Other (Specify)					30/2004 B	altimore,	Marvland
Baltimore,	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Funeral Service Licensi		H ²²	Name and	Address of Facility	ERAL HOME.	TNC	
	TO = 6 0		23a Part 1 Enter the disease or compli	cations that caused the deat		L800 No	ew Hampshi:	re Ave, Si	lver Sprin	g, MD 20904
	Pnysician .		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final				or oying, soon as cardi	ac or respiratory arre-	51,	Approximate Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	Due to (or as a consec		Liver				
į.	Examiner		Sequentially list conditions.).						
	ed sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	uence of):					
,	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a consec	quence of):	<u> </u>				
8760,	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dicai		d						
9	entifica ing ph e as th	Med	IF FEMALE:							
Вох	eath certific attending pl	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of control of the control of	al death 3	Ectopic preg			23d. Date of deli-	very Day Year
o.	at the de by the a tached	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ieath 5L	Other (spec	пу)			,
S, D	es that igned t	by Pi	Part II. Other significant conditions con	ntributing to death but not res	sulting in the ur	nderlying cau	se given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	w require been si							1 ☐ Yes	s 2□No 3□Pro	bably 4 KUnknown
ec	has b	Completed						24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
								perform 1 Tes 2	ed? death? ▼No 1 ☐ Yes	2 No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital:	TER/Outpotion		0.1	eath Check onl one		
o t		H-13	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		Injury at Work?	28d. Describe hov	nce 6 Other (Spec	f(y)
sior	Attending r death. actor: After by the funer	atio	1 Natural 5 ☐ Pending investigation	(World, Day Teal)	Injury	М	1 ☐ Yes 2 ☐ No			
Division	in Life	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)	eet, factory, o	office	28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
	pita ours eral filled		29a. Certifier 1 Certifying Phys	sician: To the best of my kno	owledge, death	occurred at	the time, date and place	e and due to the cau	isa(s) and manner as	etatod
	Vithin 24 h	edical	(Check only 2 Medical Examination)	ner: On the basis of examina and manner stated.	ation and/or inv	vestigation, in	my opinion, death occ	curred at the time, dat	te and place, and due	to the cause(s)
		Σ	29b. Signature and title of certifier	~ 0 0			icense number	29	d. Date signed (Month	
	3		Maria	Hotelm	eul		25348 		114/200	5
			30. Name and address of person who co Marcia Goldmark,			,	Road, Nor	th Potomac	. Marvland	20878
	Sta Registr			32. Pigistrar's Signa						

			1 - For State State Registrar		epartment of Health and Certificate of Death		2001	1.0077
			Hegistrar 1. Decedent's Name (First, Middle, Last)		Permicale of Deam	2. Date of Dea	Reg. No. UU4	3. Time of Death
	Physici /Medic		EARI	CARLTON H	ERRING	DEC.	Day Year 31, 2004	3:15 A M
	Examin		4a. Facility Name (If not institution, give street and r		4b. City, Town, or Location of De		4c. County of Death	
			WESTMINSTER NURSING		WESTMINSTE		CARROL	L
Г	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 □ F	7. Age (In yrs. last birtho	Months Davs Hours Mi		9. Birthy Coul 919 MAR	place (State or Foreign ntry) YLAND
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location			10d. Inside City Limits
	fler death with the Marylan r Itams 23a or 28a-f show it wit mast be redilled at	tor	MD. CARROLL		MINSTER			1X Yes 2 No
	r 28a	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cour	ntry?
	238 c	aiD	51 TIMBER RIDGE DR	•	21157		USA	
	tams	Funerai	Armed	ecedent Ever in U.S. Forces?	 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White,	
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 1 ☐ Yes 3 ☐ Widowed 4 ☐ Divorced Year or	s 24\(\Sive	1 ☐ Yes 2 ☒ No Specify:		Specify: WHI	
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show dicel Exar if ar must be redified at		15. Decedent's Education	16a. D	ecedent's Usual Occupation		16b. Kind of Business/In	
215	within 73 ene. than "n	pie	(Specify only highest grade complete	d) (C	Give kind of work done during most of w fe. DO NOT use retired)	rorking		adouy
21	filed wit Hygiens other the	Completed	8	, (110,01)	PRINTER]	DECORATING	CO.
Maryland	d d d	Be	17. Father's Name (First, Middle, Last) EARL	TOWNS		ame (First, Middle,	,	
2	should nd Men marka umatic	2	19a. Informant's Name/Relationship (Type, Print)				HERRING	0.01155
Ma	od 2 sho lith and 27 Is m		PAT CHANEY - DAUGH		lailing Address (Street and Number or I			
re,	f Hea f Hea item		20a. Method of Disposition	20b. Place of D	isposition (Name of	_	20c. Location - City or To	
E	00		1 ☐ Burial 2 【XCremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)		crematory or other place) NTY CREMATION 1	/3/05	SYKESVILLE	. MD.
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Goensee	1	22. Name and Address of Facility			
<u>-</u>	88258		In Thy thy fin		254 E. MAIN ST.	, WESTM	INSTER, MD	.21157
L			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or	t caused the death. Do not neach line.	enter the mode of dying, such as cardi	ac or respiratory arr	est,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	Dysbha	ns.			Onset and Death
	/Medical Examiner		Due t	o (or as consquence of				
	o tratt	er	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying	o (or as a consequence of):	,			
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	Demen	he:			
ó	be executed sician and burial-transit			o (or as a consequence of):				
8760,	ate he	Physician/Medical	d					
ထ	teath certifica attending pl	Med	IF FEMALE:					
Вох	death c e attend ed for us	ian	in the past 12 months?	outcome of pregnancy birth 2 Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delive Month	Day Year
o.	0 0 0	iysic	1 ☐ Yes 2 ☐ No 4 ☐ Pre 9 ☐ Unknown 9 ☐ Unk	gnant at time of death known	5 Other (specify)			.,
S, P	requires that the een signed by th nould be detache	by Ph	Part II. Dther significant conditions contributing to	death but not resulting in th	e underlying cause given in Part I.	23e. Did to	bacco use contribute to th	ne cause of death?
rds	w requires been sign should be	q pa				1 □ Y	es 2□No 3□Prob	ably 4 Dunknown
Vital Record	> 0 %	Completed				24a. Was a	n 24b. Were auto	psy findings available
Œ	The ate h page	Com				autops perform	ned? death?	npletion of cause of 2□ No
/ita	certificate	Be	25. Was case referred to medical examiner?		26. Place of De	eath Check onl on		
of	S S D	7		Inpatient 2 ER/Outpa	-		ence 6 Other (Specify	1)
	ding h. After fune	Certification:	1 Natural 5 Pending (Mo	e of Injury 28b. Tim onth, Day Year) Inju		28d. Describe ho	ow injury occurred	
Division	or Attending after death. Diractor: After in by the fune	fica	3 Suicide 6 Could not be	ce of Injury - At home, farm,		28f. Location (St	reet and Number or Rura	l Route Number
Ö	afor A s after al Dira	Certi	4 Homicide determined buil	Iding, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town	7, State)	,
	To the Hospitef or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical (29a. Certifier (Check only 2 Medical Examiner: On the	he best of my knowledge, d	eath occurred at the time, date and place r investigation, in my opinion, death occ	e, and due to the ca	ause(s) and manner as st	ated.
	To tha h within 24 To the F complete	Medi	and ma	anner stated.				
	-	~	29b. Signature and title of certifier	0 000	29c. License number D 005421		9d. Date signed (<i>Month, l</i>	Day, Year)
•	MIL		20 No.	K VIII			1/1/05	
	9		30. Name and address of person who completed ca DR. RAMAN KANERIA, N			ATNIGO	2445	7
	Sta	te	31. Date filed (Month, Day, Year) 32.	Regionar's Signature	COLM DR., WEST	IINSTER,	MD. 2115	/
	Registr		JAN 0 3 2005	Glown &	Society ,			

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

HOWEN,

Please Typ	e or Print in	Black Indelible Ink.	Ensure All Copi	es Are Legible.
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			1- For Amend Items 23	State of Maryland Ba, PtII, 25, 27, 2	/ Depai 28a c f Cert	rtment of H per ME G flicate of L	ealth and N 839 Death	lental Hyg 3/05dhb Re	iene 004	42979
	Physici /Medio		1. Decedent's Name (First, Middle, Last) ELIZABETH STAI	NT HENDRICKSO	ON			2. Date of Death Month	Day Year	3. Time of Death 1 0815 M
	Examin		4a. Facility Name (If not institution, give s Membella			-	Location of Death		4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 18	Year) 9. Bir	thplace (State or Foreign ountry)
	<u> </u>		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Loca	ation			, 1, 10	10d. Inside City Limits
	e Mary	Director	MD Carolin	le		Pr	eston			1 ☐ Yes 2 ☐ No
	with th		10e. Street and Number 6120 Harmony Ro	ad		10f. Zip Code	1655		og. Citizen of What Co United St	
	tams 2	Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. W		spanic Origin? (Sp n, Mexican, Puerto		14. Race - Ame Black, Whit	erican Indian,
036	be filed within 72 hours after death with the Maryland stal Hyglene. dd othar than "natural", or Itams 23a or 28a-f ehow evant, I'm Medicel Era niner mett be maillise at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2☐ No If Yes, Give Year or Dates:	1[☐ Yes 2☐XNo	Specify:		Specify:	White
215-0036	in 72 h n "natu Velles	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give ki	nt's Usual Occupa ind of work done d O NOT use retired;	luring most of work	in g	6b. Kind of Business	/Industry
	filed with Hygiene othar tha	Сош	Elementary/Secondary (0-12) 12	College (1-4or 5+)	Wa	itress	40.44-0-1.4	(F. 1611)	Food Se	ervice
Maryland 21	e d fa	To Be	17. Father's Name (First, Middle, Last) Walter Watts				18. Mother's Name Bessie			
Mary	カニトラ	0	19a. Informant's Name/Relationship (Type Michael Stant/So						City or Town, State, .	
	es 1 a of Hea litern rotha		20a. Method of Disposition 1XX gurial 2 □ Cremation 3 □ Re	20b. Plac	e of Disposi	tion (Name of atory or other place	! .		20c. Location - City or	
Baitimore,	Pa nen ant:	, 1	4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Service License	Ches		Cemeter			nesterto	
Ba	permit. Departr Imports any Inju	1	Milane		21	6 North	Main S	treet,	Funeral i Federal	Home, PA sburg, MD
	Physician [°]	0	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final	Naish.			, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death
~,;	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequen		noma				3,014
	7 -	ner	Sequentially list conditions, if any, leading to immediate	Due to or as a consequen	ice of):	- Caller	0	AL	400	
	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen			MAPOROVE	D BY MEDICAL EXAM	With	
98/60	cate be ohysicia the bur	edical		there		CERT	IFICATION APP			
Box 6	- CD 05	lan/Me	230. Was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal de		ctopic pregnancy			23d. Date of del	ivery
o.	The law requires that the death cert tte has been signed by the attending age 2 should be detached for use a	Physicia	in the past 12 months? 1 ☐ Yes 2☑ No 9 ☐ Unknown	4 Pregnant at time of death		Other (specify)			Month	Day Year
S,	res that igned b be deta	by	Part II. Dther significant conditions con	tributing to death but not resultin			n in Part I.		acco use contribute to	
cord	w requires that been signed b should be deta	Completed	npragar	, Anai Cancei,	пуре	rtension		1 ☐ Yes 24a. Was an		obably 4 Unknown
Vital Records,		Comp					····	autopsy perform	prior to	completion of cause of
	Hospital or Attanding Physician: The Yahours alred death. Funaral Diractor: After this certificate telly filled in by the funeral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 Ne He	ospital: 1⊿Inpatient 2□ER	/Outpatient	3□ DOA Othe	26. Place of Death		ice 6 □Other (Spe	city)
Division of	ding Ph J. After th funeral	Ilon: T	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28	b. Time of Injury	28c. Injury Work		Subject	v injury occurred	ony)
INISI	al or Attanding F s after death. Il Diractor: After d in by the funera	Certification:	2 X Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	June 5, 2004 U 28e. Place of Injury · At home building, etc. (Specify)					et and Number or Ru	ıral Route Number,
	spital or		29a. Certifier 1 PNCertifying Phys	at home	dge, death o	occurred at the time	a date and place :	120 Harm	ony Rd, Pro	stated
	To the Hospital with n 24 hours a To the Funeral Completely filled	Medical	one)	er: On the basis of examination and manner stated.	and/or inve	stigation, in my opi	inion, death occurr	ed at the time, dat	e and place, and due	to the cause(s)
4	15 15	_	29b. Signature and title of certifier	my Im		29c. License	59762	29	d. Date signed (Monti 子/ 公/の 4	n, Day, Year)
F	3		30. Name and address of person who con			•			1 0,0 1	
	Sta		31. Date filed (Month, Day, Year)	219 S. Wast			Easton,	MD 216	501	
	Registr	ar	## 12 2004	All the state of	A Comment					f

			Amend Items 23b,c,25,27,28a	aryland Per	/ Depa ME Ceri	rtment of	Health and 18/05dhb f Death	Mental Hy	/giene		2020
	Dharia		Decedent's Name (First, Middle, Last)					2. Date of D	eath		Time of Death
-	Physic /Medi	cal	TAE SUNG HWANG 4e Facility Name (If not institution, give street end number))			4b. City. Town. o	Month JULY r Location of Dea	Day 14, 2004 th 4c. Count		1:00 PM
j	Exami	ier			CNTCD		GAITHE			TGOMERY	
	Funeral			ge (in yrs. last		If Under 1 Yea	ar If Under 24 H	s. 8. Date of B	rth	T	(State or Foreign
	Director		319-70-0424 1 N 2□ F Usual Residence of Decedent	92	Yrs.	Months Day	rs Hours Mi	oct. 20	ay, Year) 0, 1911	KOREA	
	yland		10a. State 10b. County	10c. City, T	own or Loc	ation				10d. I	nside City Limits
	the Mer 28s-f.s	ctor	MD MONTGOMERY	GAI	THERS	BURG				1	☐ Yes 2X☐ No
	ith th Sor 28	Dire	10e. Street end Number			10f. Zip Code			10g. Citizen of	What Country?	
	ath w	ra	17060 KING JAMES WAY #420			2087			USA		
020	72 hours efter death with the Meryland natural', or items 23s or 28s-f show lical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 □ Yes 2 □ ☒ If Yes, Give Year or Dates:	,		as Decedent of Yes, specify Cu □ Yes 20X N	f Hispanic Origin? uban, Mexican, Pue o <i>Specify</i> :	(Specify Yes or Norto Rican, etc.)	5 14. Ra Bla Specia	ce - American Ir ick, White, etc. fy: ASIAN	
21215-0020	thin 72 hou e. en "nature	Completed	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or the complete of t		6a. Decede (Give ki life. Do	nt's Usual Occ ind of work don O NOT use reti	upation le during most of w red)	orking	16b. Kind of B	usiness/Industr	/
	ed wi	5	5		BUSIN	ESS OWN	IER		DRY CLE	ANERS	
Pug.	be filed Ital Hyg Id other	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	, Maiden Surnai	ne)	
ž	d 2 should be the and Menta T is marked traumatic ex	၉	DUCK SOO HWANG				SI HA				
Maryland	2 8 8		19a. Informant's Name/Relationship (Type, Print) IN BONG HWANG (WIFE)				et and Number or I				э)
	s 1 and of Heelth item 27 other t		20a. Method of Disposition	20b. Place	of Disposi	tion (Name of	S WAY #420	Date		20877 - City or Town, §	State
9	Ø = ± ₽		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			ntory or other pa ORTAL PAR	,	7/20/04	OLNEY,		
Baltimore,	it.		21. Signature of Funeral Service Licensee	TOTEL				PEYTON FUN		עויי	
m	Depa Impo any I		he the	40	220	וה כ כשוד	RLINGTON RI			nc nc	
	_	\Box	23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lit	the death. D						App	roximate
	Physician /Medical Examiner	16	Immediate Cause (Final disease or condition resulting in death)	Due to (or as	ti on	7	holdural H	moni	q	Ons	rvel Between et and Death
	ted nsit	nlne	b. 346	9 9 A	10	7	chryt	chod	1		
	execunand and sel-trei	Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):	^	m/	A STATE OF THE STA	MNER	
Box 68760,	leath certificate be executed ettending physician and I for use as the buriel-trensit	Physician/Medical I		Due to (or as	a conseque	ence of):	CERTIFIE	MON APPROVED	BY MEDICAL EXAM	UII arm	
	e deat he ett ied fo	sici	Part II. Other eignificant conditions contributing to death be	ut not resulting	g in the und	erlying cause g	iven in Part I.	23b. Did	tobecco use co	ntribute to the	cause of death?
P.0	that the death led by the etter detached for o	F						1 🗆	Yes 2 0	3 Probably	4 🗆 Unknown
Records,	requires been sign should be	Completed by							an autopsy ormed?	available	utopsy findings e prior to ion of ceuse
æ	The law ste hes cage 2	E O						1 🗆	Yes 2 0	1 □ Yes	
of Vital		Bec	25. Was case referred to medical				26. Place of De	eath (Check only		12.00	
Ž	Physicien: this certific	2	examiner?, 1 ☐ Wes 1 ☐ Inpatie	ont 2 ER/	Outpatient	3□ DOA O	ther: 4 ursing	Home 5□Resi	dence 6 □Oth	er (Specify)	
Ē	ding Ph. h. After thi funeral		27. Manner of Death 28a. Date of Injur		Time of Injury	28c. Inju	ury at ork?		how injury occur	réq	
Division	Attending or death. sector: After by the fune	Certification:	ZAccident investigation Several		Unkn	OWIL	Yes 2. No	Multipl			
Σ	or Attend efter death Director: A in by the f	erti	4 ☐ Homicide determined 200. Place of Injury			t, factory, office	•	City or To		er or Rural Rou	te Number,
	spital	O	Multipl 29a. Certifier 1 Certifying Physician: To the best of Cherk only.			ccurred at the t	ime date and plac	Unkno		nnor as stated	
	To the Hospital or Attending within 24 hours effer death. To the Funerel Director: After completely filled in by the fune	edical	(Check only one) 2 Medical Exeminer: On the basis of and manner sta	examination a	and/or inves	stigation, in my	opinion, death occ	urred at the time,	date and place,	and due to the o	ause(s)
	Vithiu To th comp	M	29b. Signature and title of certifier			29c. Licen	ise number		29d. Date signe	d (Month, Day,	Yeer)
			Man Cang			DI	41162	-	77/7	1420	04
	(5)		30. Name and address of person who completed cause of de								
	9/		1 2 anti 1913		e cf	cv I	71116	G'/c	in hi	D 500	P1 8
	Sta Registr			ar's Signature	hand	•					

Willie Hunter 3rd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

R.	JD		1 - State Amend Item 28	State of Maryl a per me G8	and / Depa 339 1-24-	artment of H	ealth an Death	d Mental Hy	giene 20	04	42981
ı	Physicia	n	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	er 90, 2	()(e)#4	3. Time of Death
	/Medic		Willie Lee Hunter			45 Oib T	Landing of F				11301. M
	Examin	er	4a. Facility Name (If not institution, give st 410 Elizabeth Stre	et and number)		4b. City, Town, or Salisbury)eath	4c. County Wicom		
	Funeral	-	Social Security Number	7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24		h	9. Birthi	place (State or Foreign
	Director		220-90-4776	M 2□ F	26 Yrs.	Months Days	Hours !	May 18,		Coul	AD
	pu 🌲		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	cation					10d. Inside City Limits
	faryla shor	5	MD Wicomico		Salisbur						1 ☐Xes 2 ☐ No
	the N	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Cou	ntry?
	h with	Funeral Director	1005 Fairground Dr	rive		21801			U.S	_	
	death	ner	11. Marital Status	Was Decedent Ever Armed Forces?		Was Decedent of Hi	spanic Origin n. Mexican, P	? (Specify Yes or No	- 14. Rac		can Indian,
2	or its	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:	,		/ Bla	
2	hours turel		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a, Dece	dent's Usual Occupa	ntion		16b. Kind of B		
2	n ne	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done o DO NOT use retired,	lurina most of	working			,
7	d with giene ar the	Com	8th	College (1-401 3+)		n/a	a			n/a	
yland	al Hy d oth	Be (17. Father's Name (First, Middle, Last)					Name (First, Middle,	Maiden Suman	ne)	
<u>8</u>	Ment Marke Marke	2	Willie Lee Hunter,				Linda				
	12 sh h and 7 Is rr traum		19a. Informant's Name/Relationship (Type Willie Lee Hunter,					or Rural Route Number Fruitland			Code)
บ้	1 and Healt tem 2		20a. Method of Disposition		b. Place of Dispo	sition (Name of		Date	20c. Location		own, State
<u> </u>	Pages ent of ht: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	•	matory`or other place ill Cemete		3/2005	Eden, I	VII	
Dallimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Department of Health and Mental Hygene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show importent: If item 27 is marked other then "neturel", or items 25e or 28e-f show any fingury or other traumatic event, I.a. Mealcal Eracities must be notified at an once.		21. Signature of Funeral Vervice Liminse		2:	2. Name and Addres	s of Facility	-		.10	
Ď	Depar Depar Impor any ir		23a. Part 1. Enter the disease, or complic		J	ewis N. V 1618 West	Vatson Road	Funeral H	ome _ MD 21:	301	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	e cause on each line.							Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	Gunsho	+ Wou	ndS(z)	to Re	ght Shoc	ilder ar	nd	Onsor and Dodan
	/Medical Examiner		resulting in deathy	Due to (or as a cor	sequence of): L	ett av	m				
	*	-e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Oisease or injury	Due to (or as a cor	nsequence of):					-	
	outed d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events								
Ç	e exection and an arrial-tr		resulting in death) Last	Due to (or as a cor	nsequence of):						
8/60,	death certificate be executed e attending physician and infor use as the bunal-transit	dicai	d							-	
X	leath certifica attending pl	Physician/Me	IF FEMALE:	3c. If yes, outcome of pr	egnancy				23d Da	te of deliv	erv
X D D	atten d for u	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 1 4 Pregnant at time	Fetal death 3	∃Ectopic pregnancy ∃ Other (specify)				nth	Day Year
j.		hysi	9 Unknown	9□ Unknown							
λ, T	Se De	by P	Part II. Other significant conditions con-	tributing to death but no	t resulting in the u	nderlying cause give	en in Part I.		V		he cause of death?
Cora	w require been sign should t	ted						_ 1□'	Yes 2 DiNo	3 ∐ Proi	oably 4 Unknown
Ū	> 0	ompieted						24a. Was	osy	Were auto prior to co death?	opsy findings available impletion of cause of
Z Z	iclen: The lav certificate has rector, page 2 :	O						1/Z Yes	2□No	1 XYes	2 No
VItal	siclen: certific lirector,	o Be	25. Was case referred to medical examiner?	ospital:	2 🖺 ER/Outpatie	ot 3 DOA Othe	ar	Death (Check only only only only only only only only		er (Speci	(scene)
O	g Phys er this eral di	-	27. Manner of Death	28a. Date of Injury (M, nth, Day Yea	28b. Time o	f 28c louin			how injury occur		97
Division	ttending P death. ctor: After y the funera	atio	1 Natural 5 Pending 2 Accident investigation	12 30104	Frand	AM PM	Yes 2 No	3u	bject	5h	ot
<u> </u>	ter de irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S)	pecify)	reet, factory, office		City or To	vn, State) 4 [DE	al Route Number, 1, 2 a b) eth St.
2	ours af		CO. Continue 4 Continue Physics		street	• • • • • • • • • • • • • • • • • • •	4-4 4-		lisbeire	1 1	10
	To the Hospitel or Attending Physiclen: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	sicien: To the best of my ner: On the basis of exa- and manner stated.	mination and/or in	vestigation, in my of	pinion, death	occurred at the time,	date and place,	and due t	o the cause(s)
	ro the within To the	Me	29b. Signature and title of certifier			29c. License O.C.M	number		29d. Date signe December	d (Month,	Day, Year)
-			> Carolita	llan m	d	0.6.1	1 • L. •		Decembe:	Ľ JL,	2004
•	Elex .		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type	Print) 111 Pe	enn St	, Baltimo	re. Mars	/land	21201
	200		CHROL H. AL	LAN M	Signatura			, Dareino	-c, iar	Lair	
	Sta Regist		31. Date liled (Month, Day, Year)	32. Registrar's S		land.					

			For			id / Depa		Health a	and M	lental Hygi	ene		20	0.0
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П	Physicia	an	Decedent's Name (First, Middle, L.	,						Date of Death Month	Day	Year	3. Time of 7:11	Death P M
	/Medic	al	Christina Lorai 4a. Facility Name (If not institution, gi				4b. City, Town,	or Location	of Death	Decembe	er 24,		7:11	
	Examin	er	Holy Cross Hosp					lver s		n cr	-	gomer	3.7	
	Funeral		5. Social Security Number 6.	Sex 7	. Age (In yrs.	last birthday)	If Under 1 Year Months Days	r If Under		8. Date of Birth (Month, Day,			y ce (State oi v)	r Foreign
	Director		213-82-9860	1 □ M 21X F	29	Yrs.	33,0	110010		March 4			rylan	
	land ow		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	ty, Town or Lo	cation					100	d. Inside Cit	y Limits
	Mary a-f sh	tor	Maryland Montgo	merv		K	ensingto	n					1 ☐ Yes	2 3 №
	th the	Directo	10e. Street and Number		-		10f. Zip Code			10	g. Citizen of W	/hat Countr	y?	
	ath w	ral	2907 Jennings R				208					SA		
	er de Items	by Funeral	11. Marital Status	12. Was Deced	ces?	.S. 13. 1	Was Decedent of If Yes, specify Cu	Hispanic Ori ban, Mexicar	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		- Americar k, White, et		
920	urs af	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give)		1□Yes ŽŪNo	Specify:	:		Specify.	White		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show the Medical Exactiner most be notified at	Completed	15. Decedent's E (Specify only highest g	Education		16a, Dece	dent's Usual Occu	pation	et of worki	00	6b. Kind of Bu	siness/Indu	stry	
2	Mthin no.	mpje	Elementary/Secondary (0-12)	College (1-	4or 5+)		kind of work done DO NOT use retir	-	A G. WOM	9				
7	illed v Hygie ther th	CO	12 17. Father's Name (First, Middle, Las	it)		Not	Employe		er's Name	(First, Middle, M		None		
ano	d be dental liked o	To Be	Edward Vincent							Ioffman		- /		
Maryland	shoul nd M	۲	19a. Informant's Name/Relationship	J		19b. Mailir	ng Address (Stree			I Route Number,	City or Town,	State, Zip C	code)	
Ž	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene if Health and Mental Hygiene item 27 is marked other than "natural", or Items 23a or 28a-1 show then traumatic event, I'm Medical Fracing ermant be notified an		Rosa H. Hogan/ M	lother		2907	Jennings	Road,	Ken	sington,	MD 20	895		
Baltimore,	of He of He if item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from S		Place of Dispo cemetery, crer	sition (Name of matory or other pl	ace)		ate 2	Oc. Location -		n, State	
Ë	: Pag tment tant:		`4 ☐ Donation 5 ☐ Other (Spec	eify)	A	Ceme	on Natio tery	naı	200	5 A	rlingto		rgini	a
Ba	permit. Pages 1 Department of H Important: If ite any Injury of once.		21. Signature of Funeral Service Lice	_	3	50	rancis ad 30 Unive	ess etail rsity	Mins Blvd	Funeral , W, Sil	Home I Lver Sp	nc ring,	MD 2	0901
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	Examiner		Sequentially list conditions,	b. Righ	+ ven	aricul-	r Dilat	tion.						
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	xecut and al-trar	хап	that initiated events resulting in death) Last		PIVATO		Failure	-						
8760,	ate be executed hysician and the burial-transit	icai		d										
9	rtificat ng phy as th	B	IF FEMALE:											
P.O. Box	The law requires that the death certifics ate has been signed by the attending ploage 2 should be detached for use as I	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		nth 2 ☐ Feta untat time of d	aldeath 3[Ectopic pregnan Other (specify)	су			23d. Date Mor	e of delivery oth D		ear ear
Division of Vital Records, P.	uires that the de signed by the a Id be detached f	by	Part II. Other significant conditions Hy dro (eph-1)		ath but not res	sulting in the u	nderlying cause g	iven in Part i	I.		acco use contr	ibute to the		
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Re	The lay	mo								autopsy perform 1 X Yes 2	ed? d	rior to compleath?	oletion of ca XNo	luse of
/ita	ysiclan: The is certificate director, pag	Bec	25. Was case referred to medical examiner?							(Check only one)			
of V	d is	ဥ	1X Yes 2□ No			ER/Outpatier	nt 3 DOA	then 4 No		me 5 Reside				
nc	ding F h. After funer	tion	27. Manner of Death 1 Natural 5 Pending investigati		n, Day Year)	28b. Time o Injury	W	uryat ork? ⊒Yes 2. □		28d. Describe ho	w injury occurr	ed		
Visi	Attending Physician: r death. ector: After this certifica	ertification:	2 Accident investigati 3 Suicide SCould not determine	28e. Place	of Injury - At h	nome, farm, st	reet, factory, office		-	28f. Location (Str	eet and Numbe	er or Rural I	Route Numi	ber,
ā	urs afte	O			g, etc. (Speci					City or Town,				
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	edical	(Check only 2 Medical Ex	Physician: To the aminer: On the ba and mann	sis of examina	ation and/or in	vestigation, in my	opinion, dea	ath occurr	ed at the time, da	te and place, a	and due to t	he cause(s))
	withi To t	Σ	29b. Signature and title of certifier	M.D.			29c. Licer	nse number		29	d. Date signed	(Month, D	ay, Year)	
7			100				0001=	13301	7 ((VA)	12/28	1700	4	
			John Sock,	o completed cause	of death (Ite	m 23a) (Type,	Print)	.1 (e	nyen	Mach	(n 1 % -	D.C.	202	c٦
	Sta	ate	30. Name and address of person who John Sock (31. Date filed (Month, Day, Year)	32. 7	gistrar's Sign	ature	Carles	-1	. , ,	, -000	1			-/
	Regist	rar	JAN 04	2005	CARNE	N 19	1000							

		1 - For State Registrar	State of Marylan		artment of H		nd Mental Hy	rgiene Reg. No.?	1 0 7 0 7
Pĥysio /Med		Decedent's Name (First, Middle, Last) Aubrey Monroe	Howard	***			2. Date of De Month December	eath CUU	9-Time of Death) 004 1:35 PM
Exam		4a. Facility Name (If not institution, give s Holy Cross Hospi	tal		4b. City, Town, or Silver	Sprin	g	4c. County of	
Funera Director		5. Social Security Number 230–14–9582 6. Sex Usual Residence of Decedent	7. Age (In yrs. 81	/ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bi (Month, Date of Bi (Month, Date of Bi	rth ay, Year) 9 1923 V	Birthplace (State or Foreign Country) irginia
d Z1Z15-UU3b filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or items 23a or 28e-f show ent, the Modical Examinar must be rutified at	Director	10a. State 10b. County Maryland Montgome 10e. Street and Number		y, Town or Lo Gaither				10- 60	10d. Inside City Limits 1 □ Yes 2 No
death with I	Funeral Dir	439 West Side Dr	12. Was Decedent Ever in U.	.S. 13.	20878		n? (Specify Yes or N Puerto Rican, etc.)	United S	tates American Indian,
UU30 hours after urel', or ite	d by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates:	II	1 □ Yes 2 🛣 No	Specify:	Puerto Hican, etc.)	Specify:	White, etc. Black
Maryland 21215-UU36 d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. It is marked other than "naturel, or items 23a or 28e-f show treumetic event, the Midical Examinar must be multiful at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12		(Give life.	dent's Usual Occupi kind of work done o DO NOT use retired er Carrie	during most o	of working	U.S. Post	tal Service
_ ~ ~ ~ ~	To Be C	17. Father's Name (First, Middle, Last) Oliver Howard				Magg	s Name (First, Middle gie Graves		
e, Mar tand 2 sh dealth and om 27 is m ther treum		19a. Informant's Name/Relationship (Ty) Dorothy Howard / 20a. Method of Disposition	Wife	439 1	•		or Rural Route Numb Apt. 102 Ga Date		rg, MD 20878
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Importent: if Item 27 is marked any injury or other treumetic and process.		1 Burial 2 Cremation 3 R '4 Donation 5 Other (Specify) 21. Signature / Funeral Service Licensu	emoval from State A1	emetery, crei L Soul:	matory or other places Cemeter 2. Name and Address	у	an. 4, 2005	Germanto	wn, Maryland
Dermi		23a. Part1. Enter the disease, or compli	M	10	Deer Deer	Park	Dr. Gait	hersburg,	MD 20877
Physiciar /Medica		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Sepsis Due to (or as a conseq						Interval Between Onset and Death
58760, ficate be executed XX physician and XX s the burial-transit	dicai Examiner	Sequentially list conditions, in my leading to mind a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent).	neuce of).					8 Days
Ords, P.O. BOX 61 requires that the death certific een signed by the attending pl hould be detached for use as it	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	Ideath 3	□Ectopic pregnancy □ Other (s <i>pecify</i>)	,		23d. Date of Month	•
cords, P. wrequires that been signed by	ed by Ph	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.			ute to the cause of death?
I Rec The law ate has b							24a. Wha: auto perf 1 □ Yes	opsy prid ormed? dea	re autopsy findings available or to completion of cause of ath? I Yes 2 □ No
on of ling Phys L. After this Tuneral di	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 X Inpatient 2 □ 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	of 28c. Injur Wor	er: 4 🗆 Nurs			
Division or To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia		reet, factory, office			(Street and Number own, State)	or Rural Route Number,
he Hospi n 24 hour he Funer pletely fills	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, dear ation and/or in	th occurred at the tin exestigation, in my o	ne, date and pinion, death	place, and due to the n occurred at the time	cause(s) and mann , date and place, and	er as stated. d due to the cause(s)
Withi Complete	×	29b. Signature and title of certifier Color				0 61		29d. Date signed (
()		30. Name and address of person who co	ompleted cause of death (Item	п 23a) (Туре	Print) CHAR	9. W	J. OH, M	I.P.	
S Regis	tate trar	JAN 04 20	32. Pegistrar's Signa	H. A	parle	, ,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Mary Elisabeth Hendrickson December 29 2004 2:00 P /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 5 Cumberland Court Annapolis
If Under 1 Year | If Under 24 Hrs. Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🙀 F 098-36-1360 Yrs Director 89 22 1915 New York Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b County or 28a-f show the Medical Examiner must be notified at 1 TYes 2 □ No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Cumberland Court 21401 United States or Items 23e Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☎ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3X Widowed 4 □ Divorced white 'naturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) other homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ment of Health and Mental shit: If item 27 is marked o George W. Smyth Edith Grace Ogle 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Fitzgerald/ daughter 5 Cumberland Court Annapolis, MD 21401 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Page...
riment of H
scient: If its 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory Dec. 30, 2004 Baltimore, MD 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee Impor any in 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ocons **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Failus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 ding physician Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for u 3 Ectopic pregnancy in the past 12 months? Month Year 4☐ Pregnant at time of death 5 Other (specify) P.O. I ed by the a detached f 9 Unknown 9 Unknown been signed to should be deta Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No 1 ☐ Yes 2 No 1 Tyes director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Tes 1 Inpatient 2 EN/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 4 hours after death uneral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide within 24 hours a To the Funeral C To the Hospitel 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

Registrar

Name and address of person who co

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2002

d cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED 1, 1/4/05, LDB, DOR Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** V. RUTHELLA HOSKINS 29,2004 Pcember /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner River Kent hester town der 1 Year | If Under 24 Hrs. hester Hospital Center 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1 M 200 F **Funeral** Months Days Hours 236-42-425 Usual Residence of Decedent 36-42-4251 8,1927 Director West Virginia 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits other traumatic event, the Medical Example must be notified at 1 Yes 2 No MD Director Kent 10e. Street and Number 10g. Citizen of What Country? within 72 hours after death with Avenue aroline or itams 23a 21661 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: te by f Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 OWN Home Homemaker Pages 1 and 2 should be filed inent of Health and Mental Hyginns: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be Payne Coleman 2 Joseph Gordon Hallie Isabel) 19a. Informant's Nam elationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5728-Caroline Ave. Rock Hall Maryland 21661

20b. Place of Disposition (Name of cometery, crematory or other place)

Date 20c. Location - City or Town, State Joseph 20a. Method of Disposition Hoskins permit. Pages 1 Department of H Important: If ite eny injury or of once. 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Mid Share Cremation 1/04/05 Cambridge, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Home P. A. 21. Signature of Funeral Service Licenses C, 510 Washington St. Cambr. dge, Maryland 21613 23a. Part. Efter the disease, or complications that caused the death. show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dehydation **Physician** 200 /Medical Due to (or as consequence of): Examiner En d End Stage vena
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and I-transit The law requires that the death certificate be executed 4 mont aftern Due to (or as a consequence of): burial-1 Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 DEctopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ page 2 should be 5 1 ☐ Yes 2√Q No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 20 No 20 No 1 Yes Was case examiner? Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Inpatient 2 ER/Outpatient 3 DOA this funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide ō within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

State Registrar

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

FREDERICK DELBOY, M.D.

JAN 0 4

DHMH 17 Rev 1/2001

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MD

32. Registrar's Signature

30. Name and agdress of person who completed cause of death (Item 23a) (Type, Print)

2005

29c. License number

6602 CHURCH HILL ROAD, ST. 200, CHESTERTOWN, MD 21620

29d. Date signed (Month, Day, Year)

5 0

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** TERRELL Month Day JOHNSON 017:20 AM SEPTEMBER 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HEALTHCARE CITY AGNES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Navs | Hours | Min | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 5EPTEMBERI, 44 12M 2□F Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits MARYLAND BALTIMORE CITY 1 Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? "natural', or Items 23a or 2504EXECOMBE CIRCENORTH UNITED STATES Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be ealth and Mental JOHNSON TERRELL CRYSTAL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTIMORE, MIHRYLAND 2504 ENECOMBE CIRCLE NORTH B if item 27 l MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place)

NENI CATHEDRAL

20c. Location - City or Town,
CEMETARY CCTCERC 2004 BALTIMORE, MA

22. Name and Address of Facility Scint Agrics Height (2:142) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State OCTOBERG 2004 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee I LYMON GOO SWITH CATON A VENUE BALTIMORE, MARKAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Prysician PRETERM DELIVERY UNKNOWIN /Medical Due to (or as a consequence of): Examiner CHORIO AMNIONITIS UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examiner use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Injury Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) SEPTEMBER 11, 2014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATONSVILLE, MARYLAND PARSONS, MD 6400 BALTIMORE NATIONAL PIKE \$5 State JAN 2 0 Registrar

State of Maryland / Department of Health and Mental Hygiene $2 \cap \{l_k\}$ 42987 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Frances W. Johnson December 2004 11:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Mar. 27, 1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖳 F 173-22-1985 76 Yrs. Director Wash., Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f shover the Medical Examiner must be notified at 1 X Yes 2 □ No Director D.C. Washington 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 1216 - 42nd Place, N.E. 20019 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, White, etc. African Black, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 □ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nit. Pages 1 and 2 should be filed within artment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "injury or other traumatic event, Ite Ma. Elementary/Secondary (0-12) College (1-4or 5+) 4+ Researcher Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Williams Hattie Mae Rucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Sharon King - Daughter 1917 Hickory Hill Lane, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or Lincoln Memorial Cem. 1/5/2005 4 Donation 5 Other (Specify) Suitland, MD 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home once 4001 Benning Rd., N.E. Wash., DC 20019 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final Physician disease v condition resulting in death) Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Yea 4☐Pregnant at time of death 5 Other (specify) be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Urinary Tract Infection page 2 should 1 Yes 2 No 3 Probably 4 Mnknown Completed Breast Neoplasm 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Dehydration 1 Yes 2**X** No 2 🗌 No of or Attending Physician: after death. Director: After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Nnpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32332 December 30, 2004 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 9801 Georgia Ave., #220 Silver Spring, MD S.K. Gupta, M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JAN 0 5 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 9 **Physician** Year 10ng 0225 AM Dec 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital

cial Security Number 6. Sex 7. Age (In yrs. last birthday) Rockville
If Under 1 Year | If Under 24 Hrs. Montgomery 8. Date of Birth Day, Year) Dec. 19, 1917 9. Birthplace (State or Foreign Country) South Korea **Funeral** 1 □ M 2 🙀 F N/A Director Usual Residence of Decedent r than "natural", or Items 23a or 28a-f show the Madical Exempler must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√ Yes 2 No Director Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 113 Crofton Hill Lane 20850 South Korea Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 Ñ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1☐ Yes 2☐ No Specify: δ 3 X Widowed 4 ☐ Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Importent: If Item 27 is marked other It any injury or other traumatic event, the once. Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unobtainable Unobtainable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yong Choi/son 113 Crofton Hill Lane Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Fort Lincoln Crematory 12/31/04 4 Donation 5 Other (Specify) Brentwood, MD 21. Sign nure of Funeral Service Lize 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician Sepsis day, /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physiclen and for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐ Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4. Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 549 2004 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christine Le 9901 Medical Center Dr; Rockville, MD 31. Date filed (Month, Day, Year) State Registrar JAN 05 2009

			Amend Items 2,23	a,25,27,28 28a-f	per	ME, C	partment of 839, 01/18 e <i>rtificate of</i>	Death	nentai Hy	Reg. No.] 4	42989
	Physicia		1. Decedent's Name (First, Middle, L	ast) Kel	l				2. Dete of De Month	Dey 17-	2004 Year	3. Time of Death
	/Medica Examine		4a Fecility Name (If not institution, gi	ve street end number)			4b. City, Town, or Lo	ocation of Deet	th 4c. County	of Death	0035
			Washington Adven-	tist Hospi	tal			Takoma Pa	rk	Montg	omerv	
4	Funeral Director		205-28-9533	Sex 7. A	ge (In yrs. le	est birthda 66 Yrs.		If Under 24 Hrs.	8. Date of Bir (Month, Da Jul 4,	rth ay, Yeer)	9. Birthpl Count Mary	ace (State or Foreign ry) Land
	pue ≱	-	Usuel Residence of Decedent 10a. Stete 10b. County		10c, City	. Town or	Location				10	d. Inside City Limits
	Varyler f show	5										1 □ Yes 2 🗓 No
	death with the Marylend rms 23a or 28a-f show r must be notified at	Funeral Director	MD Montgom 10e. Street end Number	ery	Ken	singt	On 10f. Zip Code			10g. Citizen of	Whet Count	rv?
	23a or	٥	11001 - 31									
	death	Jera	11304 Palisades C	12 Mac Decedent	Ever in U,S	5. 13	20895 Was Decedent of	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No	United 0- 14. Rac	e - America	an Indian,
21215-0020	urs efter	۾	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 X If Yes, Give Year or Dates:	No		If Yes, specify Cut 1 ☐ Yes 2 No		Rican, etc.)	Bla Specif		tc.
5-0	natural',	e e	15. Decedent's E (Specify only highest gr	ducation		16e. Dec	edent's Usual Occu	pation	ina	16b. Kind of B	White usiness/Inde	ustry
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	filed wi Hygian ther th	5		3		Sect	ion Chief					
Pu	= 1 4	Be	17. Fether's Name (First, Middle, Las	t)				18. Mother's Name	e (First, Middle	, Maiden Suman	ne)	
3	should be nd Mantal merked o	ှ	Peter Kell					Helen D				
Maryland	2 8 8 8	ı	19a. Informant's Name/Relationship	(Type, Print)		19b. Ma	iling Address (Stree	t and Number or Run	el Route Numb	er, City or Town,	Stete, Zip	Code)
	ges 1 and 2 should it of Haaith and Mar If item 27 is marke or other traumatic	1	Bonnie C. Kell/W:	fo	ook Di	1130	4 Palisad	es Court,	Kensin	gton, M	2089	5
ō	it of the or of		20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 [☐Removal from State		metery, cr	ematory or other pla		Date	20c. Location	- City or Tov	vn, State
ţ	nit. Paratmen ortant: injury		4 ☐ Donation 5 ☐ Other (Speci	fy)		sape	ake Crema	tory 2	ov 19	Beltsvi	11e, 1	MD
Baltimore,	permit. Pages 1 and Department of Haalth important: If item 27 any injury or other ti once.		21. Signature of Funeral Service Lice	nsee D	m003	382	Rapp Fune	eral & Cre Ave. Sil	mation	Service	s	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	oplications that cause	d the death.	Do not e	nter the mode of dyi	ng, such as cardiac	or respiratory a	urrest,		Approximate Interval Between
	Physician							mplicatio				Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition	and.	-			mpricatio				
*3 %			resulting in death)	a.			equence of):				Ī	
	Sit ad	in e		b	35	12	onces.			111		
, 0,	lificate be executed g physician end es the buriel-transit	edicai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				equence of):	CERTIFICATION	M. S. W	EDICAL EXAMINES		
68760,	hysk the b	000	that initiated events resulting in death) Last	<i>0.</i>	Due to (or	es e conse	equence of):	PATRA	PEROVED			
Box 6			·	d				CERTIFICA				
	death	SICIE	Part II. Other significant conditions	contributing to death b	out not resul	ting in the	underlying cause gi	ven in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
s, P.O	requiras thet the death certificate be exected signed by the attending physician encould be datached for use es the buriel-tra	y Phy				_			10	Yes 2000	3 ☐ Probe	ably 4□ Unknown
Records,	200	Completed by Physician/M							24a. Was perfo	an autopsy ormed?	avai	re autopsy findings ilable prior to ipletion of cause eath?
æ	The law ate has t page 2 s	E							45	Yes 250No		Yes 2k No
ta	ificat or, p		25. Was case referred to medical	<u> </u>				26. Place of Death			'U	Tes ZAUNO
5	Physician: this cartific ral director,	0 26	examiner?	Hospital:	ant 2016	R/Outpation	ent 3D DOA Oti	205		dence 6 ⊟Oth	er (Specify)	
0	arthie eral		27. Menner of Deeth	28a. Date of Inju	-	28b. Time				how injury occur		
Division of Vital	Attending in death.	Icatio	2 Natural 5 Pending investigation 3 Suicide 6 Could not be	n 11/04/20	004 L	Injury Jnkno	wn ^M ¹□	Yes 2 No		ct fell	D/	Davids Alexander
<u>≥</u>	rs after at Direct led in by		4 ☐ Homicide determined	Home	c. (Specify)		treet, factory, office		City or Toi	Street and Numb wn, State) Kei allisad	nsingt	on,MD
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this cartificate has completely filled in by the funeral director, page 2	edical Certification:	29a. Certifier 1 Sertifying Pr (Check only one) 2 Medical Exa	nysician: To the best niner: On the basis o and manner st	t examinatio	ledge, dea	th occurred at the ti nvestigation, in my	me, date and place, a	and due to the	cause(s) and ma	nner as sta	ted.
	To the comp	-	29b. Signature and title of certifier		V		29c. Licens		2.0	29d. Date signe		
	10		30. Name end address of parameters				, Print)	005128			18-0	
			Anushiravan Dad				al Center	Dr.#201,	Rockvi	ille, MD	. 208	50
W. St.	State Registra	7 6	31. Dete filed (Month, Day, Year) JAN 1 8 2005		er's Signatu		de					
DHI	IH 16 Rev 6/95		ALTO T O COO.	The state of the s	- Find	1						

04-08373	
Edwin Lisane	
RJD	_

		1 - State Registrar		Ce	ertificate of L	Death		Reg. No.	2004	4299
		1. Decedent's Name (First, Middle, L	ast)			-	2. Date of De			3. Time of Death
hysici /Media		Edwin Dion L	isane				Dec.	27,	2004	2 a
xamir		4a. Facility Name (If not institution, gi		per)	4b. City, Town, or	Location of Deat	1		County of Oeath	1
		1806 Ray Leona			Landove	r		Pr	ince Ge	eorges
neral ector		5. Social Security Number 6. unk	Sex 7. 1 ☆ M 2 ☐ F	Age (In yrs. last birthda). 20 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Date 4 / 20)	th ay, Year) 198	Cou	place (State or Fore intry)
		Usual Residence of Decedent								
r than "neturar, or itams 23a or 28e-1 snow the Medical Exerciner must be notified at	_	10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Lim
Se-1	Funeral Director	MD P.G.		Riverda						1 \ Yes 2 □ 1
Z E E		10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Cou	intry?
8 23e	ra	6287 67th Cour	- T		20737				S.A.	
Te de	nue	11. Marital Status	12. Was Decede	es?	 Was Decedent of His If Yes, specify Cuba 	ispanic Origin? (S ın, Mexican, Puer	pecify Yes or No o Rican, etc.)	>-	 Race - Ameri Black, White 	
틸	by F	Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date		1 ☐ Yes 2 🙀 No	Specify:			Specify: Bla	ack
描	ed	15. Decedent's I			edent's Usual Occupa	ation		16h Ki	ind of Business/Ir	
1	Completed	(Specify onfy highest g Elementary/Secondary (0-12)	rade completed)	(Giv	re kind of work done of DO NOT use retired	during most of wo	rking	100.70		ndustry
9	E	Elementary/Secondary (0-12)	College (1-4 2 1/2		dent			Co	llege	
ent,	BeC	17. Father's Name (First, Middle, Las				18. Mother's Nar	ne (First, Middle	·		
	To B	Ed Lisane				Denita	Baker			
Is marked aumatic ev	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Street a			er, City o	r Town, State, Zi	ip Code)
1 tr		Ed Lisane/fath	ner	6287	67th Ct	. River	dale,	14 2	0737	
r othe		20a. Method of Disposition	DRomoval from Ct	20b. Place of Dis	position (Name of rematory or other place		Date	20c. Lo	ocation - City or T	own, State
ury o		1 ☑ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		Glenwoo	d Cem.	1/3	3/05	Was	h. D.C.	
Importent: if ite any injury or ot once.		21. Si mature of Funeral Service Lice	ensee	, ,	22. Name and Addres	ss of Facility	odaes a	nd.	Edwards	
= 2 A		June 200	waro	(2)	3910 Sil	ver Hil	l Rd S	:::u .	land Mr))
ician dical		Immediate Cause (Final disease or condition resulting in death)	_a _ G40	ch line. 1560 f		g, such as cardia			ust	Approximate Interval Between Onset and Death
dical niner	Examiner	disease or condition	a. Gue to (or b. Due to (or c.	ishot would					lest	Interval Between
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		1 - For State Registrar	•	epartment of Health and Certificate of Death	Mental Hygie	211114 1.20
Physici /Medi	cal	Decedent's Name (First, Middle, L EBELIN MARIBEL BI As. Facility Name (If not institution, gi	JENO LORA	4b. City, Town, or Location of De	December	Day Year 31, 2004 10:30P 4c. County of Death
Examir	ner	National Institut	es of Health	Bethesda		Montgomery
Funeral Director			Sex 7. Age (In yrs. last birth	Months Days Hours Mi		
a-f show	to	10a. State 10b. County Dominican	10c. City, Town	or Location Ojohando Santiago		10d. Inside City Li 1X Yes 2
ntal Hygiene. od other then "natural", or items 23a or 28e-f show event, itte Medical Ezama ar must be molified at	neral Director	10e. Street and Number Av Yapus Dumit ed 11. Marital Status		10f. Zip Code None 13. Was Decedent of Hispanic Drigin? If Yes, specify Cuban, Mexican, Pue		Citizen of What Country? DOMINICAN REPUBL 14. Race - American Indian,
ural', or ite	d by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1⊠Yes 2⊡ No <i>Specify:</i> Do	minican	Black, White, etc. Specify: Hispanic
ene. then "nat he Medica	Completed	15. Decedent's 8 (Specify only highest gi Elementary/Secondary (0-12)	ade completed) (College (1-4or 5+)	Decedent's Usual Decupation Give kind of work done during most of w life. DO NOT use retired)	orking	b. Kind of Business/Industry
d other	Be	17. Father's Name (First, Middle, Las Leonardo Bueno			ame (First, Middle, Mai	Executive Sales den Sumame)
of Health ar if Item 27 is or other treu	J.	19a. Informant's Name/Relationship Alberys Bueno — 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 1	Brother Av Zhemoval from State 20b. Place of Ecemetary,	Mailing Address (Street and Number or R Yapus Dumit ed. 96 Disposition (Name of crematory or other place)	Apt 202 Appare Date 202 Appare 202	
Department Importent: any injury conce.		4 □ Donation 5 □ Other (Special Signature of Funeral) Service Lice		no Avenica 1-7 22. Name and Address of Facility Marshall's Funera 4217 9th St. N.W.	-2005 <u>Dom</u> 1 Home, Inc	incăn Republic
nysician Medical xaminer ne prijal-transil	Examiner	23a. Faft1. Enter the disease, or con thock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Aspergillosis Due to (or as a consequence of Caracty): - host disease). turnal hemoglobinu		Approximate Interval Betwee Driset and Deat 2 months 3 months more than one year
~ <u>@</u>	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ②No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	1	23d. Date of delivery Month Day Year
ate has been signed by the attending phoage 2 should be detached for use as th	þ		contributing to death but not resulting in t	he underlying cause given in Part I.		Use contribute to the cause of death 2 ☑ No 3 ☐ Probably 4 ☐Unkr
ate has been si page 2 should t	Completed				24a. Was an autopsy performed	
iis certific director,	To Be (25. Was case referred to medical examiner? 1 \(\text{Yes} 2 \) \(\text{No} \)	Hospital: 1 区Inpatient 2 口 ER/Outp	atient 3 DOA Other: 4 Nursing	eath (Check only one) Home 5 - Residence	e 6 □Other (Specify)
leath. tor: After the funer	Certification:	27. Manner of Death 1 ANatural 2 Accident 3 Suicide 4 Homicide 2 Pending investigation of Could not I determined	De Diese of laine, At home form	ury Work? No 1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, St	t and Number or Rural Route Number,
24 hours Funerel stely filled	Medical Ce	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysicien: To the best of my knowledge, miner: On the basis of examination and/and panner stated.	death occurred at the time, date and place or investigation, in my opinion, death occ	e, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
within 2 To the comple	Me	29b. Signature and the or certifier	JL	29c. License number		Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien P Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** NORMAN LEE LONG, SR. 30, 2004 1:20 AM DEC. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CARROLL LUTHERAN VILLAGE WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Director 216-14-6423 81 11/1/1923 MARYLAND Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or iteme 23a or 28a-1 ehow other treumatic event, the Medical Examinar must be notified at ₩Yes 2 No Director CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? MARK WAY, APT. 21158 205 ST. 316 USA Funerai deeth 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. ont: If Item 27 is marked other then "naturel", or Ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WW II 1 ☐ Yes 2X No Specify: à Specify: WHITE 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT GOVERNMENT 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARVEY LEE LONG HELEN MARIAN PHELPS ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORMAN L.LONG, JR. -SON 401 LONDON CT., WESTMINSTER, MD. 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 0 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Importent: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) MEADOW BRANCH CEM. 1/2/05 WESTMINSTER, MD. Signature 22. Name and Address of Facility FLETCHER FUNERAL HOME ce Licensee 254 E. MAIN ST., WESTMINSTER, MD. 23a. Part1. Enter the disease shock, or heart failure. se or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-transit law requires that the deeth certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death signed by the eld be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autoosy perform certificate Yes To the Hospitel or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Lo 2 No Other: 4 Nursing Home 1 Yes ☐ Inpatient 2 ER/Outpatient 3□ DOA 5 Residence 6 Other (Specify) within 24 hours effer death.

To the Funeral Director: Affer thi
completely filled in by the funeral i 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours e To the Funeral (Two Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MJL ALIX H 3055845 4 and address of person who completed cause of death (Item 23a) (Type, Print) 21158 × BREW 57 Heuin Whe Circle, We 51mm 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 03 2005 Registrar I franks

		•	For State Registrar	State of Ma	ryland / Depa	artment of H		_	iene 004	42993
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	20 WARD				2. Date of Dear Month DECENSOL	Day Ye	
ı	Examin		4a. Facility Name (If not institution, give: 540) WBH PARO R	street and number)		4b. City, Town, or		ith	4c. County of D	A
	Funeral Director		220-50-6206	7. Age M 2√2 F	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir			Birthplace (State or Foreign Country)
	Maryland I show	ō.	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the hard or 28a-	Dire	Maryland Montgome 10e. Street and Number		Bethesda	10f. Zip Code		1	0g. Citizen of What	Country?
036	i within 72 hours after death with the Maryland liene. I then "natural", or items 23a or 28a-1 show the Medical Examinar must be notified at	by Funeral	5401 Westbard Ave. 11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	#1413 12. Was Decedent E Armed Forces? 1 □ Yes 2 □ N If Yes, Give Year or Dates:	0			Specify Yes or No- rto Rican, etc.)		White, etc.
Maryland 21215-0036	within 72 ho lene. then "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wi	orking	16b. Kind of Busine	ess/Industry
and 2	al Hyg I otha	Be	17. Father's Name (First, Middle, Last)	4	Chen	nist		ame (First, Middle, i		al
Jaryl	es 1 and 2 should be of Health and Mental I itam 27 Is marked or rother traumatic eve	ပ္	Francis Michael I 19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street		hy Louise Rural Route Number		e, Zip Code)
Baltimore, 1	Pages 1 and nent of Health ant: If itam 27 ary or other t		Catherine L. Jense 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)		20b. Place of Dispo	matory or other plac	Jan.	Date	Spring Mar 20c. Location - City Alexandri	or Town, State
Balti	permit. Page Department of important: If any injury or once.		21. Signature of Funeral Service Licens	1 Cole	Fr 50	Name and Address ancis J.	ss of Facility Collins	Funeral	Home, Inc	c. ng.MD 20901
	Physician		23a. Part1. Enter the disease, or comb shock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused ne cause on each lin	the death. Do not ent e.	er the mode of dyin	g, such as cardia	ac or respiratory arm	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions.	Suicion	a consequence of):					
8760,	e be executed sician and e burial-transit	ai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
O. Box 6	The law requires that the death certificate be executed tate as been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	□Ectopic pregnancy □ Other (specify)	,		23d. Date of Month	delivery Day Year
Δ.	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	ntributing to death but			en in Part I.	23e. Did tol		e to the cause of death? Probably 4 Unknown
of Vital Records,		Completed						24a. Was a autops perform	ry prior ned? deat	e autopsy findings available to completion of cause of n? fes 2 \(\sumbole \text{No} \)
f Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1/ Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatie	nt 3 DOA Oth		eath <i>(Check only on</i> Home 5 Reside		Specify)
	nding Ph th. : After th s tuneral		27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day	Year) Injury	Wor	yat k? Yes 2 No		ow injury occurred	-cartiero
Division	To tha Hospital or Attanding P within 24 hours after death. To tha Funaral Diractor: After t completely filled in by the lunera	Certification;	3 Suicide 6 Could not be determined		iry - At home, farm, st			28f. Location (St City or Town BRUBSON)	7, State) 5(00) 1	Rural Route Number, WEST BAND AVE
	a Hospi 24 hou a Funar letely fill	edical	29a. Certifier Check only 0 Phy 1 Certifying Phy 2 Hedical Exami	sician: To the best of ner: On the basis of and manner sta	of my knowledge, deat examination and/or in ted.	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	ce, and due to the courred at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
	To the within You the Comple	Me	29b. Signature and title of certifier	m	D (ow	29c. Licens			9d. Date signed (M	• • • • • • • • • • • • • • • • • • • •
			30. Name and address of person who co		eath (Item 23a) (Type,	Print)	like Book	evium Me	20852	-
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Degistra	r's Signature					

Paulette Law Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-08433 For Unpend item#23a, PII, 27, 28a-f, permit G839, 1/21, 05 TT Registrar crn 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 4:15 P M 29, Paulette Law December 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner 4900 Blue Wing Court Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Yeal 948 9. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2120 F 57 56 Director 215 52 8545 June 19, 1947 Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at 1 Yes 2 No Directo MD Columbia Howard 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number ō itams 23e 4900 Blue Wing Court #103 21045 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 ☐ Yes 2 📆 No If Yes, Give 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ➡ Divorced White 'naturel' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) 12 M/ADisabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Paul Hinton Presley Mary Coralie Montgomery ..nt. Pages 1 and 2 sho.
Department of Health reimportant: if there any injury r. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda C. Thompson/Sister 6229 Southern Maryland Boulevard Lothian, MD 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Rurial 2 Cremation 3 Removal from State 14 Donation 5 Other (Specify entombment Ft. Lincoln Cemetery 1-4-2005 Brentwood, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 ne Coll 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mixed Drug Intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of) the burial-Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year ţ 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 2 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 99 3 ☐ Probably 4 █Unknown 1 ☐ Yes 2 ☐ No Acute Pyelonephritis Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 XYes 2 No 2 No Physician:

page certificate funeral director

Be

Certification: To

Medical

State

Registrar

25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence (Nother (Specify) at scene 1XYes 2 No

1 🔀 Yes

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6XX ould not be determined 3 🗌 Suicide 4 - Homicide

28a, Date of Injury (Month, Day Year) 12/29/2004 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Fndhjury 4:12 p^M 1 ☐ Yes 2 XNo

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State) 4900 Bluewing Ct #103 Columbia, MD

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

LE MI

O.C.M.E.

December 30, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LI. M.D LING 111 Penn Street, Baltimore, MD 21201

scene

and manner stated.

31. Date filed (Month, Day, Year)

2005 **JAN 0 5**



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within 24 hours after deat To the Funeral Director:

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State of Maryland / Department of Health and Mental Hygiene 🛭 🗎 👢 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Carrol Marie Mitchell December 2004 1:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Wheaton Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Feb. 9, 1 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 ☐ M 2 🔽 F 577-88-5679 48 Yrs Virginia Director Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 3348 Curtis Dr., #303 20746 Itams 23a United States Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "naturel", or Itams 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black. Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+) government Data Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Mitchell, Sr. Gloria Balthrop ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trains once. Christina Mitchell/Daughter 3348 Curtis Dr., #303, Suitland, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 1/4/2005 ` 4 ☐ Donation 5 ☐ Other (Specify) Wash., DC 21. Signal re o l'uneral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 levie 23a. Part / Enter the disease, or complications that caus if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final CARCINOMA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo 2∏ No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 XNo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) th (Item 23a) (Type, Print) 30. Name and address of person who completed cause of di STIVE 31. Date filed (Month, Day, Year) State JAN 0 7 2005 Registrar

		,	1 - For State Registrar	State o	f Maryla	nd / Depa <i>Cei</i>	artment of rtificate o	Health a	and M		giene Reg. No.	A (1)	**************************************	29	96
			1. Decedent's Name (First, Middle,	Last)	-					2. Date of Dea	ath			3. Time of	Death
	Physici /Medio		Mae C. Mi	les						Month Dec.	30 Day	, Ye 2004	- 10	0:44	РМ
	Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town	or Location				County of D			
			Prince Georges	Medica1	Center	•	Cheve	rly			Pı	ince	Geor	ges	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Yea Months Day		24 Hrs.	8. Date of Birth (Month, Day	h			e (State o	r Foreign
	Director		578-16-9731	1 □ M 2 □ X F	88	Yrs.	World is Day	riouis	IVIII 1.	Sept 2		L916 S			olina
	p ,		Usual Residence of Decedent 10a. State 10b. County		10- 0	ity, Town or Lo									
	anyla shov	٦			1	•							10d.	Inside Ci	-
	18a-f	Director	D.C.		W	ashingt								1 ☑ Yes	2 NO
	vith ti	i	10e. Street and Number				10f. Zip Code				10g. Citi	zen of Wha	Country	?	
	hours after death with the Maryland tural', or Itams 23a or 28a-f show al Examinat must be notilised an	rai	2519 High Stre				2002					USA			
	er de Itami	Funeral	11. Marital Status	Armed Fo		J.S. 13. \	Was Decedent of If Yes, specify Cu	f Hispanic Ori Iban, Mexicai	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		14. Race - A Black, V	vmerican Vhite, etc		
9	s aft	by F	1 Never Married 2 Marrie 3 X Widowed 4 Divorced	If Yes, Gir	ve		1 ∐ Yes 2 🙀 N	o Specify:				Specify: B	1ack		
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7	with ene. ther	mc	Elementary/Secondary (0-12) 8th.	College (1-4or 5+)		Domesti	,			ъ	rivat	2		
O	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or Itams 23s or 28s-f show of other than "natural", or Itams 23s or 28s-f show event, the Medical Evaning must be notilised at	ŭ	17. Father's Name (First, Middle, L	ast)			Domeser		er's Name	(First, Middle,					
al	d be l	To Be	Johnnie M. Joh	nson						a B. Kei		,			
Maryiand	2 should be and Mental is marked isumatic ev	-	19a. Informant's Name/Relationsh	p (Type, Print)		19b. Mailir	ng Address (Stre	et and Numbi	er or Rura	I Route Numbe	r City o	r Town Stat	a Zin Co	ndo l	
Š	nd 2 Ith al 27 is		Danatha Dana /C	takan in	1										
ā,	Hea Hea tem othe		Dorothy Reese/S 20a. Method of Disposition	ister-in-	20b.	Place of Dispo	Dubois sition (Name of	2.7		ate		cation - City			
<u></u>	ages ant of t: # I		1 ABurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			cemetery, crem ort LInc	natory or other p	1	1-07	_05 R		wood,		,	
Baltimore,	artme ortan injur		21. Signature of Funeral Service L		FC		. Name and Add			1					
n	permit. Pages I and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev		PMan	0 00	,		217 9th							011	
			23a. Parti Enter the disease, or o		aused the dea							, , ,		proximate	
			shock, or heart failure. List of immediate Cause (Final	nly one cause on e	each line.					-	651,		Ini	terval Bet	ween
	Physician /Medical		disease or condition resulting in death)	_ a			o Vascu	lar Di	sease	<u> </u>					
	Examiner			Due to	(or as a conse	quence of):									
		-	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conse	quence of):							_		
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	al-tra	Examiner	that initiated events resulting in death) Last	c	(or as a conse	quence of):						-	-		
04/8	icate be executed physician and s the burial-transit	ai													
ρΩ	ficate physis the	edicai		_ d.											
XOD	death certif e attending id for use a	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome of pregn	ancy						3d. Date of	delistent		
	atte	ciai	in the past 12 months?		ointh 2 Fet nant at time of		Ectopic pregnar Other (specify)	су			-	Month	Da	y Y	'ear
j.	the c y the ichec	Physician/M	9 Unknown	9□ Unkn											
<u> </u>	w requires that the death certif been signed by the attending should be detached for use a		Part II. Other significant condition	s contributing to de	eath but not re	sulting in the ur	nderlying cause o	oven in Part I		23e. Did to	bacco u	se contributi	e to the c	ause of d	eath?
ecords,	puires n sign lld be	d by	Hemorrhagic Inf	arct						1 🗆 Y	es 2[]No 3□	Probable	y 4 ∑ U	Inknown
증 당	law req as beer 2 shou	Completed	Hypertension							24a. Was a	ID.	24b More	autonou	findings	labla
Ē	0 - 0	m d								autops	sy	24b. Were prior death	to comple	etion of ca	ause of
VItal	ician: Th certificate rector, pag	C	25. Was case referred to medical							1 Tes	2 X No		′es 2□	No	
5	Physician: this certific	o Be	examiner?	Hospital:	0.5	Zenio	C	thos		(Check only or					
Ö	Physical dia	-	27. Manner of Death			28b. Time of	1 3 DON	4 🗀 INU		ne 5 Reside			pecify)		
0	ding Phy th. After thi funeral o	tior	1 XNatural 5 ☐ Pending 2 ☐ Accident investiga		of Injury th, Day Year)	Injury	W	ork? ∐Yes 2 ⊡∣		.04. 2000/120 11	J 11 11 1 1 1 1 1 1	, 00001100			
S	deat deat ctor: y the	fica	3 Suicide 6 Could no	ot be	of Injury - At h	nome farm stre	eet, factory, office			28f. Location (S	treet and	d Number or	Pural P	nuto Alumi	hor
DIVISION	or lefter Dire	ertification;	4 ☐ Homicide determine	buildi	ng, etc. (Spec	ify)	oot, radiory, onio	,		City or Town			nurarno	Julio IVulii	Jer,
	To the Hospital or Attending PI within 24 hours effer death. To the Funeral Director: After the completely filled in by the funeral	0	29a. Certifier 1 Certifying	Physician: To the	best of my kn	owledge, death	Occurred at the	time date en	d place a	and due to the a	augo/a)	and manner	ac etate	d	
	24 h 24 h e Fui etely	edicai	(Check only 2 Medical E	xaminer: On the b	asis of examin	ation and/or inv	estigation, in my	opinion, dea	th occurre	ed at the time, d	ate and	place, and	due to the	e cause(s)	
	Vithin o thi ompl	Me	29b. Signature and title of conflier)/			29c. Licer	nse number		2	9d. Date	e signed (Mo	onth, Day	(, Year)	
1	->		1	Th-			D	21520			11.	2/ 1	• . ´	,	
Λ	(L)		30. Name and address of person w	to completed caus	sa of death /lin	m 232\ /T.		31528			1/3	0/00	7		
L	U			, ,	·		Orive Ch	0370 - 1	МТ	20705					
	Sta	te	Margaret Akpai 31. Date filed (Month, Day, Year)	■ 2. R	egistrar's Sign	ature		everty	, LID	• 40/83					
	Registr	_	IAN 0 6 20	05	me de	bose	Be								

			1 - For State Registrer	State of Ma	-	epartment <i>Pertificate</i>			nd Mental H	ygien	200		2007
			1. Decedent's Name (First, Middle, Las	t)					2. Date of I			3.	Time of Death
	Physici /Medio		Leo (Gerard	McNiff				Decemb		ay Y 9, 200	04 6	:00 A. M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or	Location of	Death	4	c. County of		
			3654 Edelmar Terr					Sprin			Mont	gomery	
	Funeral		5. Social Security Number 6. Se	ox 7.Age XIM 2□F	e (In yrs. last birtho	Months	Days Days	If Under 2 Hours	Min. (Month,	Day, Year	7)	9. Birthplace Country)	(State or Foreign
	Director	ļ	Usual Residence of Decedent		89 ^{*r}	s.			Dec.1	7, 19	915	F	PA
	land ow		10a. State 10b. County		10c. City, Town	or Location						10d. lr	nside City Limits
	Mary -1 sh	ğ	Maryland Montgom	le r v	Silv.	er Sprin	10					1	□Yes 2X No
	r 28a	Director	10e. Street and Number	.019	·	10f. Zip (10g. C	itizen of Wha	at Country?	
	h witi	0	3654 Edelmar Terr	ace		20	906				USA		
	deat	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. Was Decede	ent of His	spanic Orig	in? (Specify Yes or I	No-	14. Race -	American In	dian,
9	or lite	교	1 ☐ Never Married 2 ☐ Married	1X Yes 2 □ N If Yes, Give	vo 1943 –	1 ☐ Yes 2		Specify:	Puerto Rican, etc.)			White, etc.	
21215-0036	hours after death with the Maryland lural; or Itams 23a or 28s-1 show al Exertirer must be notified at	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:	1946						Specify:	White	e
Ϋ́	net	Completed	15. Decedent's Ed (Specify only highest grad		(0	ecedent's Usual live kind of work	done di	uning most	of working	16b. l	Kind of Busin	ness/Industry	,
12	within ane. Ithan	g.	Elementary/Secondary (0-12)	College (1-4or 5	i+)	fe. DO NOT use	,				_	-	
7	Hygie Hygie thar t	ပိ	17. Father's Name (First, Middle, Last)	1		Supervi		18 Mother	's Name (First, Midd			tal Se	rvice
Maryland	d be antal	Be C		cNiff				TO. WICKIES					
Z	should Me mark matic	은	19a. Informant's Name/Relationship (T		19h M	lailing Address	Street a	nd Number	Viola or Rural Route Num		Daley	ato Zin Code	N
<u>≅</u>	nd 2 s lth an 27 ls		Eileen M. Poveromo						Rockville			. ,	*
ē,	tam tam tam		20a. Method of Disposition	Daugneer	20b. Place of D	isposition (Name	e of	wau,	Date	-		ty or Town, S	
5	age and or or or or or or or or or or or or or		1 ☑ Burial 2 ☐ Cremation 3 ☐: '4 ☐ Donation 5 ☐ Other (Specify					1	1/2/2005	A 7	. 029.		ee a
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23s or 28s-f show any injury or other traumatic evant, the Medical Evantinar must be notified at anose.	-	21. Signature of Funeral Service Licens		ALLINGUE	22. Name and	Address	of Facility	1/3/2005 DeVol Fur	Arı	Homo	n, vir	ginia
ñ	Per Per Per Per Per Per Per Per Per Per		Muchand	Lely	lun				k Dr., Gai				20877
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death. Do not						Sourg		roximate val Between
	Priysician		Immediate Cause (Final			D.						Onse	et and Death
	/Medical		disease or condition resulting in death)		vascular a consequence of)							10	years
	Examiner		Opposed the flat and divine	Hyperter	nsion								
	70 ==	ner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury		a consequence of):								
	nd	Examiner	that initiated events	c									
Ö,	e exe sian a urial-		resulting in death) Last	Due to (or as a	a consequence of):								
8760,	cate be executed physician and the burial-transit	dicai		d								-	
9	entific ding p	'Me	IF FEMALE:	22- 15									
Вох	ath cattendate us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal death	3 □Ectopic pre				- 1	23d. Date o Month	,	Year
o.	the death certifi y the attending I iched tor use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or death	5 Other (spec	c#y)					,	
0	res that the death certifi igned by the attending I be detached tor use as	/ Ph	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in th	e underlying cau	use dive	n in Part I.	23e. Dio	I tobacco	use contribu	ute to the cau	se of death?
Records,	es ign be	d by							1 🗆	Yes 2	№ No 3{	☐ Probably	4 Unknown
S	w require been s should	Completed							24a. Wa	6 30	24h Wai	ro autonou fic	ndings available
Be	9 4 B	mo							— aut	opsy formed?	prio	or to completion th?	on of cause of
Vital		e Cc	25. Was case referred to medical					00 DI	1 Tes		1 🗆	Yes 2□N	10
>		o B	examiner?	Hospital:	nt 2 ☐ ER/Outpa	tient 3 DOA			of Death Check onlining Home 5 🖾 Re		6 DOthor	(Enneita)	
of		\vdash	27. Manner of Death	28a. Date of Injur	y 28b. Tim	e of 28	c. Injury	at	28d. Describe			(Specify)	
<u>0</u>	Attanding r death. actor: After y the fune	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	/ Year) Inju	M M	Work?	r es 2 □ No	0				
Division	l or Attano atter deatl Diractor: in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	iry - At home, farm	, street, factory,	office		28f. Location	(Street ai	nd Number (or Rural Rout	e Number,
ā	rs after rs Dira red in by	Cer			(0,00)	and the Viscos			0.1, 0.7	om, oldi	•/		
	To the Hospital or At within 24 hours after o To the Funeral Direc completely filled in by	edical	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exami	sician: To the best of	of my knowledge, d	eath occurred at	the time	, date and	place, and due to the	e cause(s) and manne	er as stated.	auca(c)
	To the P within 24 To the F complete		5/10)	and manner sta	ted.				Occurred at the time				
Ł	To To	Σ	29b. Signature and title of pertifier	, ,	22	29c.	License	number		29d. Da	te signed (A	Month, Day, Y	rear)
1	5 +1		1 JUSTAEN	mmi	100		D 20)535		Dece	mber 2	29, 20	04
·			30. Name and add as of person who c						100 n . t	1	16	1 . 1 0	0017
	Sta	1	Dr. Roger Stevenso 31. Date filed (Month, Day, Year)					, # 2	ou, Bethe	sda,	mary.	Land 2	ηρι/
	Registr	- 100	JAN 042	005 Sere	r's Signatur	ypare							

		•	For Amend #20b State State Registrar 1/5/05 AAOO Healt	ite of Marylai h Dent omh	nd / Depa <i>Cei</i>	artment of rtificate of	Health and Death		giene () ()	4	42998
			Decedent's Name (First, Middle, Last)	T Dept Giri				2. Date of De	ath	V	3. Time of Death
	Physici /Medic		Irma Dora Mayers					Decembe	r 30, 20	004	10:00 PM
	Examin	er	4a. Facility Name (If not institution, give street 1959 Marconi Circle	and number)			or Location of De napolis	eath	4c. County o		Arundel
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2		. last birthday) Yrs.	If Under 1 Yea Months Days		Irs. 8. Date of Birt in. (Month, Pa Aug. 11	, 1920	Cour	lace (State or Foreign try) rland
	land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or La	cation				1	0d. Inside City Limits
	Mary a-f sh	tor	Maryland Anne Arund	el		A	nnapolis	3			1 ☐ Yes 2 No
	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or Items 23e or 28e-f show event, ite Modical Evanites must be notified at	Funeral Director	10e. Street and Number 1959 Marconi Circle			10f. Zip Code	21401		10g. Citizen of W		itry?
	ems a	iner		as Decedent Ever in the med Forces?		Was Decedent of f Yes, specify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No		- Americ	an Indian,
36	irs afte	by Ft	If']Yes 2,∏2No ∕es, Give arorDates:		1 □ Yes XXN	Specify:	,	Specify:		ite
21215-0036	72 hou natura	ted	15. Decedent's Education (Specify only highest grade com	-11.	16a. Dece	dent's Usual Occu	pation	working	16b. Kind of Bus	siness/Ind	dustry
121	C 2 19	Completed	Elementary/Secondary (0-12) Co	llege (1-4or 5+)		kind of work doni DO NOT use retir Secretar		HOMING	Canvas	Dwe	duata
d 2	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)		1	Secretar		Name (First, Middle,			duces
/lan	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, II e M	To Be	Henry Vogel					na (unknow		,	
Maryland	ges 1 and 2 should it of Health and Men if item 27 Is marke or other traumatic	•	19a. Informant's Name/Relationship (Type, Pl Gordon D. Mayers/hu	_{int)} sband	19b. Mailir 1959	ng Address (Stree Marconi	t and Number or Circle	Annapoli	er, City or Town, S .s, Maryl	State, Zip Land	Code) 21401
Baltimore,	permit. Pages 1 and 2 Department of Health s Importent: If item 27 It any injury or other tra ance.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Remov	aldram Ctata	cemetery, crer	sition (Name of natory or other pl		Date	20c. Location - (
Him	it. Paritmenitrent:		' 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee			rk Cemet Cewetery		4/2005 John M. T	Baltimor		
Ва	Depar Impo		H. Secott Ron	naski	1	17 Duke	of Glouc	ester St.	Annapol	is,	MD 21401
	1 5 115		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the dea se on each line.	ath. Do not ent	er the mode of dy	ing, such as card	diac or respiratory ar	rest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	MENENS	570mg						Onset and Death
	Examiner		ſ	Due to (or as a conse	quence of):						
_	D ≃	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):						
	and I-trans	Examin	that initiated events c	Due to (or as a conse	quence of):					-1	
38760,	icate be executed physician and s the burial-transit	dicai E		500 10 (01 03 0 001130	question off.						
_			IF FEMALE								
Вох	eath certifi attending I for use as	lan/N	in the past 12 months?	yes, outcome of pregr □Live birth 2 □ Fet	tal death 3□	Ectopic pregnan	су		23d. Date Mon		ry Day Year
o.	that the death certif ed by the attending detached for use a:	Physician/M	1 Vas 2 Wo	□Pregnant at time of □Unknown	death 5	Other (specify)					
٥.	The law requires that ate has been signed b page 2 should be deta	by Pr	Part II. Other significant conditions contribut	ing to death but not re	sulting in the u	nderlying cause g	iven in Part I.	23e. Did to	obacco use contri	bute to th	e cause of death?
Vital Records,	w require been sig should b							101	res 2. Ze No ∶	3 🗌 Prob	ably 4 □Unknown
3ec	e law r has be	ompieted						24a. Was	sy pr	ere autorior to coreath?	psy findings available apletion of cause of
alF		e Col	25. Was case referred to medical					1 ☐ Yes	2 ☑ No 1		2□ No
Ϋ́	Physicien: this certific ral director,	0	examiner? 1 Yes 2 No Hospit	al: 1 ☐ Inpatient 2 [☐ ER/Outpatier	nt 3 DOA	ther	Death <i>(Check only o</i> g Home 5 Z Resid		r (Specifi	/1
n of	er fe	on: T	27. Manner of Death 1 Natural 5 Pending	a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inj			now injury occurre		
Division	or Attending ifter death. Director: After in by the fune	icati	2 Accident investigation	Disas et leines Ant		M 1[Yes 2 No	004 1	24		1.0
Div	tal or Attendii s after death. al Director: Al ed in by the fu	Certification:	4 Homicide determined	 Place of Injury - At I building, etc. (Spec 	nome, rarm, str city)	eet, factory, office	•	City or Tov	Street and Numbe vn, State)	r or Hura	I Houte Number,
	Hospit 24 hour Funera tely fills	Medical C	29a. Certifier (Check only one)	: To the best of my kr In the basis of examin and manner stated.	nowledge, death nation and/or in	h occurred at the vestigation, in my	time, date and pla opinion, death o	ace, and due to the courred at the time,	cause(s) and man date and place, a	ner as st nd due to	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	/		29c. Licer	ise number		29d. Date signed	(Month,	Day, Year)
			- Chesa			J36	0161		1/3/20	05	
			30. Name and address of person who completed the RIF	ed cause of death (Ite		Print)	DR	AWNA	vales	415	21401
	Sta		31. Date filed (MAN Day, Year) 2005	3 Registrar's Sign		1011-1	2/1	1000	1.0	1	
	Regist	rar	2,111 0 3 2003	10 to 10	de d	11000					

			For State Registrar		State o	f Marylar		artmen rtificate			and M	lental Hy	giene Reg. No.	001	1	42999
	Physici	20	1. Decedent's Name (First, Mic	idle, Last)								2. Date of De. Month	ath Day	Ye	ar	3. Time of Death
	/Medic		CRAIG, LEWI									DEC		29 20	004	1:09 P ^M
	Examin	ier	4a. Facility Name (If not institut							Location of	of Death			ounty of D		
			NATIONAL NAVA 5. Social Security Number	L MEI		7. Age (In yrs.	last hirthday)	BETH If Under		If Under:	24 Hrs	8. Date of Bird		NTGOM		ice (State or Foreign
	Funeral Director		433-69-5004		M 2□F	21		Months	Days	Hours	Min.	Jan. 1	y, Year)	00	Countr	siana
			Usual Residence of Decedent	1	1							Jan. 1	0, 10	001 1	_001	Stalla
	how		10a. State 10b. Cour				ty, Town or Lo								10	d. Inside City Limits
	Ba-f a	cto	LA Bossi	er Pa	arish	Во	ssier									1 ZWes 2 No
	ਜ਼ੈ ਨੂੰ ਰੂਪ ਰੂਪ ਰੂਪ	Dire	10e. Street and Number					10f. Zip					10g. Citize	n of What	Countr	y?
	s 23s	rai	2405 Brookside		IO Was Door	edent Ever in U	10 12		7111		=in2 /Cn	and Was as No		USA I. Race - A		n Indian
10	ter de	Funeral Director	11. Marital Status 1XXNever Married 2 ☐ M		Amed Fo	rces?	7.5.	Yes, spec	ify Cuba	n, Mexican	i, Puerto	ecify Yes or No Rican, etc.)	· '	Black, W	Vhite, et	tc.
036	urs al	P	3 Widowed 4 Divord		If Yes, Giv Year or D	re 2004		1 ☐ Yes	No D&	Specify:			8	pecify.W	nite	:
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Exercit et rivet be notified at	Completed	15. Deced	ent's Educ	cation		16a. Dece	dent's Usua kind of wor	I Occupa	ition	t of work	ina	16b. Kind	of Busine	ess/indu	ıstry
21	ithin le.	nple	Elementary/Secondary (0-12		College (1	-4or 5+)	life.	DO NOT us	e retired,)	i or work	.,g	110			
S	filed with Hygiene. Ither ther		12 17. Father's Name (First, Midd	(n. (net)				Soldi	er	19 Moths	de Name	(Circh Middle		Army		
and	buld be fi Mental H arkad ot atic avar	Be	Gene Nelson	e, Last)								e (First, Middle, J. Burne		umame)		
Maryland	should Ind Men marks	2	19a. Informant's Name/Relation	nship (Tv	oe. Print)		19b. Mailir	na Address	(Street a			A Route Number		Town Stat	e Zin (Code)
Ma	and 2 sho salth and n 27 le mu		Lois J. Nelson					-				sier Cit				, , , , , , , , , , , , , , , , , , , ,
ē,	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. If Health and Mental Hygiene if the strain of thems 23a or 28a-1 show item 27 Is marked other than "natural", or Items 20a or 28a-1 show other traumatic avant. Ite Medical Execution can be notified at		20a. Method of Disposition				Place of Dispo	sition (Nan	ne of	-1		Date		ation - City		m, State
Ë	Pages nent of h int: If its ury or o		1 X Burial 2 ☐ Cremation ↓ ☐ Donation 5 ☐ Other		emoval from		llcres			":	1/5/	05	Haug	hton,	LA	
Baltimore,	parmit. Pages 1 and Department of Health Important: If itam 27 any injury or other tr once.		21, Signature of Neer Servi	cente	Del	Day C	HCT!	2. Name an Murp 510 W	d Addres	s of Facilit	, Hç	me rlingto				
			23a. Part1. Enter the disease shock, or heaft failure.	or compli	cations that c	aused the dear								A 22	2203	Approximate
	Dhusisian		Immediate Cause (Final												1	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a a		CATIONS (or as a consec		KAPNE	L WO	OND C) F I I	IE NECK			-	
	Examiner						,									
	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ا		or as a consuc	juence of):									
	nd nd transi	Examiner	tnat initiated events	o												
8760,	cate be executed obysician and the burial-transit	E	resulting in death) Last		Due to	or as a consec	quence of):									
87	physicate to be the total	dica		0	-										+	
Вох 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	2		come of pregni		Ectopic pr				255100	23	d. Date of	deliven	у
	the atte	sicie	in the past 12 months? 1 Yes 2 No			ant at time of o		Other (sp						Month		Day Year
P.0	that the di	Phy	9 ☐ Unknown Part II. Other significant cond	itione con	tobuting to d	anth hut not roo	ulting in the u	adach ias a		n in Dont I		22a Did I	obacco ua	a anatribut	o to the	cause of death?
ds,	signe signe	1 by	Part II. Other signmeant cond	ittons con	inibating to di	Jan Dut Hot 165	suiding in the d	ndenying G	ause give	miniranti.			res 21X			bly 4 Unknown
Ö	w requir been si should I	etec														
Records,	has ge 2	Completed										24a. Was autor perfo			to com	sy findings available pletion of cause of
Vital		e Co	25. Was case referred to med	oal							15 1	-43	2□No	¹X `		2 □ No
Ξ		To Be	examiner?		ospital: 1 X	npatient 2	ER/Outpatier		Othe	C		n <i>(Check only c</i> me 5 ☐ Resid		Other (Spacify)	
of	g Physer this	n: T	27. Manner of Death			of Injury th, Day Year)	28b. Time o		Bc. Injury	at		28d. Describe I			spacity)	
ion	Attending I r death. actor: After by the funer	atio	Z C MOOIGOITE	stigation	12/1	6/04	1420	М	Work	es 2 🗆 l	No	Com	bat			
Division	f or Attence after death Diractor; I in by the	Certification:		ld not be imined	28e. Place buildi	of Injury - At h	ome, farm, str		, office			28f. Location (S City or Tov	Street and	Number o	r Rural	Route Number,
	Hospital 24 hours a Funaral D		29a. Certifier 1 Certif	vina Phys	rician: To the	hact of my kny		-	- 4 4b - 4-	o doto oo	d place	100				
	To the Hospital or Attending Phyiling 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical	(Check only 2 Medic	al Examir	ner: On the b	asis of examina	ation and/or in	vestigation,	in my op	e, date and inion, deal	d place, a	and due to the ed at the time,	date and p	na manne lace, and	r as sta due to t	ted. the cause(s)
	To the Vithin 2 To the complet	Ž	29b. Signature and title of cert	//	7-	15		1	. License				29d. Date	signed (M	lonth, D	ay, Year)
	18		1/1/2	_	2 /	8	-		E113	(AR)			12	3	2	2004
K	(2)		30. Name and address of pers				m 23a) (Type,			RESEA		BLVD. 3	BLDG.	102		
Þ	Sta Regist		31. Date filed (Month, Day, Ye			egistrar's Sign		A.	JOKV	THE	<i>1</i> 111 2	_0000				
			JAM & C	5003	June		1									

	,	1 - For Stata Registrar	State of Maryland /	Department of Health and Certificate of Death		ne 2004	4300
Physici /Medio	cal	Decedent's Name (First, Middle, Last Alfred F, Nayl As Facility Name (If not institution, give	or	4b. City, Town, or Location of Dea	2. Date of Death Month December	Day Year	
Funeral	er	Manor Care Potoma 5. Social Security Number 6. S	ex 7. Age (In yrs. last b	Potomac	S. 8. Date of Birth	** L	
Director		147–20–7157 Usual Residence of Decedent 10a. State 10b. County	M 2□F 77	Yrs. Moritus Days Hours Milh	october 17,		Jersey 10d. Inside City Limit
r 28a-f sho	rector	Maryland Montgon			100	. Citizen of What Cou	1 X Yes 2 N
ms 23a o	Funeral Director	10714 Potomac Ten	12. Was Decedent Ever in U.S.	20854 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puei	J	Jnited Sta	tes
ral', or ital Examine	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1947–1949		rto Rican, etc.)	Black, White,	etc.
gene. Tre Meulcal Exaciner: wat be nutified at	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) Professor of Genetics	rking	b. Kind of Business/Ir esearch In	,
othe vent,	To Be Co	17. Father's Name (First, Middle, Last) Michael Gwazdzie		18. Mother's Na	me (First, Middle, Ma. Niedzwied:	den Sumame)	Screde
of Health and Menta filtem 27 is markad rother traumatic e	-	19a. Informant's Name/Relationship (Catherine Naylor/		b. Mailing Address (Street and Number or R 3303 Bannockburn Driv	ural Route Number, C 7e, Brtheso	ity or Town, State, Zij da, MD 20	817
Department of he Important: If Item any injury or oth once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ **Donation 5 ☐ Other (Specify	Removal from State George	etown University 20	mber 28 04 W	ashington	D.C.
Import any inj		21 Ignature of uneral Service Licen	Gudn	22. Name and Address of Facility Co	lumbia Mor Box 58007	tuary Serv Washingto	vices, In on, D.C.2
ysician Medical		23a. Part1. Enter the disease, or companies shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. Do one cause on each line.	o not enter the mode of dying, such as cardia	c or respiratory arrest		Approximate Interval Between Onset and Death
aminer purial-translt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	b. Hypertension Due to (or as a consequence	o of):			û Years
~ 00	icai E	2201	Due to (or as a consequence	9 01):			
은 드	TO		. d				
attending ph for use as th	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	h 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive	ery Day Year
gned by the attending ph be detached for use as th	ā	23b. Was decedent pregnant in the past 12 months? 1 \(\subsection \text{Yes} 2 \subsection \text{No} \)	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	5 Other (specify)			Day Year
ie has been signed by the attending ph age 2 should be detached for use as th		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	5 Other (specify)		Month co use contribute to ti 2 \[\text{No} \] 3 \[\text{Prot} \] 24b. Were autoprior to co death?	Day Year he cause of death? pably 4 **QUnknow posy findings availate mpletion of cause o
this certificate has been signed by the attending phat director, page 2 should be detached for use as the	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions of the conditions of	23c. If yes, outcome of pregnancy 1	in the underlying cause given in Part I. 26. Place of De Other: 4 Nursing I	1 ☐ Yes 24a. Was an autopsy performed	Month co use contribute to th	Day Year he cause of death? pably 4 \(\overline{\partial}\) Unknow posy findings availab mpletion of cause of
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doatn. ctor: Afler this certificate has been signed by the attending ph y the funeral director, page 2 should be detached for use as th	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnancy 1	in the underlying cause given in Part I. 26. Place of De Other: 4 & Nursing II. Time of Injury M 1 Yes 2 No farm, street, factory, office	24a. Was an autopsy performed. 1 Yes 2X atn (Check only one) Home 5 Residence 28d. Describe how in the cause of the ca	Month co use contribute to th	Day Year The cause of death? Dably 4 Winknow Dably 4 Winknow Day 1 Day Indings availabe Day 1 Day Indings availabe Day 1 Day Indings availabe Day 1 Day 1 Day Indings availabe Day 1 Day